STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI	PLE CO	NSTRUCTION 00	(X3) DATE : COMPL	
THIE TENT	or conduction	155723	A. BUILDIN B. WING	G		06/26/	
NAME OF F	PROVIDER OR SUPPLIE	R	ST		DDRESS, CITY, STATE, ZIP CODE		
RIVER P	OINTE HEALTH C	AMPUS			ALAXY DR VILLE, IN 47715		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRE:		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
F0000							
	This visit was to State Licensur	for a Recertification and re Survey.	F0000				
	Survey dates: 22, 25, 26, 20	June 18, 19, 20, 21, 12					
	Facility numbe Provider numb AIM number:	per: 155723					
	Survey team: Amy Wininger 20, 21, 22, 25, Diane Hancoc Vickie Ellis, RN Barbara Fowle	k, RN N					
	Census bed ty SNF: 48 Residential: Total: 85	pe: 37					
	Census payor Medicare: Other: 57 Total: 85	type: 28					
	Residential sa	mple: 7					
		es reflect state findings lance with 410 IAC					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

TITLE

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155723	A. BUILD B. WING	ING	00	COMPLETED 06/26/2012				
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR							
RIVER P	OINTE HEALTH CA	MPUS		EVANSVILLE, IN 47715						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PI	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE			
	Quality review of 2012 by Bev Fa	completed on July 2, aulkner, RN								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 2 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIM DDIG	00	COMPLETED
		155723	A. BUILDING	- <u></u> -	06/26/2012
			B. WING	ADDRESS CITY STATE ZIR CODE	
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE	
DI) (ED D		AMBUO		SALAXY DR	
RIVERP	OINTE HEALTH CA	AMPUS	EVANS	SVILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0156	483.10(b)(5) - (1	0), 483.10(b)(1)			
SS=B		SHTS, RULES, SERVICES,			
	CHARGES				
	The facility must	inform the resident both			
	orally and in writ	ing in a language that the			
	resident underst	ands of his or her rights and			
	all rules and reg	ulations governing resident			
		ponsibilities during the stay in			
		facility must also provide the			
		notice (if any) of the State			
		r §1919(e)(6) of the Act.			
		must be made prior to or			
		and during the resident's			
	•	such information, and any			
		it, must be acknowledged in			
	writing.				
	The facility must	inform each resident who is			
	•	inform each resident who is aid benefits, in writing, at the			
		n to the nursing facility or,			
		nt becomes eligible for			
		items and services that are			
		ng facility services under the			
		or which the resident may not			
	•	se other items and services			
		ffers and for which the			
	,	charged, and the amount of			
	-	e services; and inform each			
		nanges are made to the items			
	and services spe	ecified in paragraphs (5)(i)(A)			
	and (B) of this se	ection.			
		inform each resident before,			
		admission, and periodically			
		ent's stay, of services			
		acility and of charges for			
		ncluding any charges for			
		ered under Medicare or by			
	the facility's per	alem rate.			
	The feelite	furnish a written description			
		furnish a written description			
	of legal rights wh	iich includes:			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 3 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	t .			ALAXY DR		
DIVED D	OINTE HEALTH CA	MDHC			VILLE, IN 47715		
RIVER	OINTE HEALTH CA	RIVIFUS		EVAINS	VILLE, IN 477 15		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	the manner of protecting under paragraph (c) of this					
	procedures for e Medicaid, includ assessment und determines the e non-exempt resc institutionalizatio community spou resources which available for pay institutionalized or her process o eligibility levels.  A posting of name	the requirements and stablishing eligibility for ing the right to request an er section 1924(c) which extent of a couple's purces at the time of an and attributes to the se an equitable share of cannot be considered ment toward the cost of the spouse's medical care in his f spending down to Medicaid mes, addresses, and					
	telephone numb client advocacy survey and certif licensure office, program, the pro network, and the and a statement complaint with th certification ager abuse, neglect, resident property non-compliance requirements.  The facility must requirements sp	ers of all pertinent State groups such as the State fication agency, the State the State ombudsman election and advocacy a Medicaid fraud control unit; that the resident may file a ne State survey and necy concerning resident and misappropriation of y in the facility, and with the advance directives					
	written policies a advance directiv include provisior written information concerning the r	and procedures regarding es. These requirements as to inform and provide on to all adult residents ight to accept or refuse cal treatment and, at the					

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Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 4 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DINC	00	COMPL	ETED
		155723	B. WING			06/26/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPLIS			VILLE, IN 47715		
					VIELE, IIV 17710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG		n, formulate an advance	<u> </u>	TAG	BELLEER		DATE
	•	•					ļ
	directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.						ļ
	·	•					
		inform each resident of the					
		and way of contacting the					
	physician respor	nsible for his or her care.					
	The facility must	prominently display in the					
		formation, and provide to					
	,	pplicants for admission oral					
		mation about how to apply for					
		re and Medicaid benefits, and					
		efunds for previous payments					
	covered by such		F0.1				07/26/2012
		view and record	F01:	56	F 156		07/26/2012
		lity failed to ensure			Res #8, #87 and #169 were		
	residents were	informed of their			provided a copy of resident rig	hts.	
	resident rights	during their stay in the			Completion Date 7-26-12		
	facility, for 3 of	4 residents					
	interviewed reg	garding resident			Res #8 was provided an		
	council, in that	residents were not			explanation of Medicare		
	periodically info	ormed of their resident			non-coverage.  Completion Date 7-26-12		
	rights. (Reside	ent #87, Resident #169,			Completion Date 1-20-12		
		and failed to ensure a			There were no other residents		
		care non-coverage			affected and through inservicir		
		o 1 of 3 residents who			will		
	•	for review of appeal			ensure resident rights are		
	rights. (Reside	• • • • • • • • • • • • • • • • • • • •			provided periodically and		
					non-coverage letters are sent <b>Completion Date 7-26-12</b>		
	Findings includ	۵.			Completion Date 1-20-12		
		o.			Activity staff inserviced on		
	1 Docidont #9	37 was interviewed on			requirement of resident rights	to	
					be provided.		
		a.m. Resident #87			Business office manager		
		ent rights have not			inserviced on non-coverage		
	been reviewed	. Resident #87			criteria and cut letter		
	İ		I		requirements.		I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPLET	ED
		155723	B. WIN			06/26/20	012
			B. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
1							(4.5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION DATE
IAU				IAU	Completion Date 7-26-12		DATE
		acility did not have			Completion Date 7-20-12		
		il meetings and usually			Activity Director will intervie	w 3	
	_	sistant would come to			skilled residents		
		ask her questions.			randomly/week to ensure the	ey	
		s quarterly BIMS (Brief			acknowledge receipt of		
		ental Status) score			resident rights.		
	•	5/7/12 was 15/15,					
	indicating her le	ong term and short			Executive Director will audit		
	term memory is	s intact.			Medicare non-coverage log		
					weekly to ensure compliance	•	
	2. Resident #1	69 was interviewed on			with requirement of notification.		
	6/21/12 at 9:30	a.m. Resident # 169			notification.		
		acility did not have			Monthly QA meeting will		
		il meetings and no one			include the review of the log		
		her resident rights with			and cut letters as well as the		
		# 169's annual BIMS			interview audits x3 months a	ind	
					quarterly thereafter.		
		12 indicated a 15/15,					
	_	ong and short term					
	memory is inta	Ct.					
		B was interviewed on					
		0 a.m. Resident # 8					
	indicated she h	nad never attended a					
	resident counc	il meeting and did not					
	know the facilit	y had a resident					
	council. Resid	ent #8 indicated her					
	resident rights	have not been					
	reviewed. Res	ident #8 indicated she					
	did not know w	hat her resident rights					
		it #8's BIMS score was					
		3/14/12 and indicated a					
	•	indicating her long					
	•	memories were intact.					
	מווע אווטונ נכוווו	memories were intact.					
	On interview w	ith the A.D. (Activity					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
				<u> </u>		ı	215
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>		IAU			DATE
	-	21/12 at 10:15 a.m.,					
		hat she did not usually					
		esidents on the Health					
		he indicated the					
		ity Director met with					
		the Assistant Activity					
	Director had in	dicated she had					
	reviewed the ri	ghts with the residents					
	during the resid	dent council meetings.					
	Resident #87,	Resident #169,					
	Resident #8 ind	dicated they had not					
		ident council meetings.					
		3.					
	The "Resident	Move-in Guide,"					
		the ED (Executive					
		22/12 at 4:00 p.m.,					
	· ·	esidents have the right					
	io be fully liftor	med of their rights.					
	l						
		ew on 06/22/12 at 8:15					
		S.O.M. (Business Office					
	, ,	indicated Resident #8					
	had exhausted	her Medicare benefits.					
	The B.O.M. fur	ther indicated, at that					
	time, she didn't	t know she was					
	supposed to pr	ovide a letter when					
	Medicare bene	fits were exhausted.					
	In an interview	with the HFA (Health					
		strator) on 6/22/12 at					
	,	indicated Resident #8					
		ceived a notice of					
	Medicare Non-						
	I WICGIGGIC INOII-	oovorago.					
	The Form Instr	ructions for the Notice					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

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If continuation sheet Page 7 of 101

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	E SURVEY PLETED 6/2012
	PROVIDER OR SUPPLIER OINTE HEALTH CAMPUS	3001 G	ADDRESS, CITY, STATE, ZIP C ALAXY DR WILLE, IN 47715	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	of Medicare Non-Coverage provided by the HFA on 06/22/12 at 4:00 p.m indicated, "When to deliverA Medicare providermust give an advance, completed copy of the Notice of Medicare Non-coverage to beneficiariesreceiving skilled nursing,not later than 2 days before the termination of services"  3.1-4(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet

Page 8 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155723	B. WING	3 <u> </u>		06/26/	2012
	PROVIDER OR SUPPLIER			3001 G/	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN 47715		
					VIZZZ, IIV III 10	-	(M.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CH/ (INJURY/DECLII A facility must im resident; consult and if known, no representative or member when the resident which the potential for intervention; a si resident's physic status (i.e., a det or psychosocial sthreatening concomplications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483	NE/ROOM, ETC) Immediately inform the I with the resident's physician; tify the resident's legal Ir an interested family Intere is an accident involving It results in injury and has Ir requiring physician I gnificant change in the I real, mental, or psychosocial I retioration in health, mental, I resident in either life I resident in either life I reatment due to adverse I reatmen					
	resident and, if k representative or when there is a c assignment as s a change in resid State law or regu paragraph (b)(1  The facility must update the addre	also promptly notify the snown, the resident's legal or interested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in ) of this section.  Tecord and periodically less and phone number of the epresentative or interested					
	Based on obse record review, ensure the phy problems with a	rvation, interview, and the facility failed to sician was notified of a colostomy appliance ents reviewed for	F01:	57	F 157  Resident #1's physician was notified of current condition of stoma site.  Completion Date 7-26-12		07/26/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

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AND PLAN OF CORRECTION    155723	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCES  REFERENT TAG.  SUMMARY STATEMENT OF DEFICIENCES.  THE EVANSVILLE, IN 47715  CRECH DEFICIENCY MIST BE PERCEDED BY PULL REGULATORY OR USE DENTRYING INFORMATION;  COOLSOSTOMY CARE in a sample of 2 residents who met the criteria for colostomy care. (Resident #1)  Findings include:  Hospice Nurse #2 and LPN #1 were observed on 08/18/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. Resident #1. Resident #1. Was observed at that time to be grimacing throughout the procedure and stated. "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated.  In an interview at that time, LPN #1 indicated Resident #1 was receiving Diffucan (an oral antifungal medication) for colostomy exerciation. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburgerwhen he goes [has a bowel movement] it just sits on that skin and then it leaks." The Hospice Nurse stated, at that time, "We are gonna come out Thursday (6/21/12) and assess for new appliance." LPN #1 was then observed to apply a new colostomy appliance to the exconiated skin surrounding the stoma.  The clinical record of Resident #1.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING	00	COMPLETED
NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES  PREFIX TAG  COLOSTOMY CARL DEFINITY MIST BE PRECEDED BY PULL TAG  COLOSTOMY CARL DEFINITY OF DEFICIENCIES  residents who met the criteria for colostomy care: (Resident #1)  Findings include:  Hospice Nurse #2 and LPN #1 were observed on 06/16/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. Resident #1 was observed at that time to be grimacing throughout the procedure and stated, "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated.  In an interview at that time, LPN #1 indicated Resident #1 was receiving Difflucan (an oral antifungal medication) for colostomy excoriation. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburgerwhen he goes [has a bowel movement] it just sits on that skin and then it leaks." The Hospice Nurse stated, at that time, "We are gonna come out Thursday (8/2/11/2) and assess for new appliance." LPN #1 stated, at that time, "We are gonna come out Thursday (8/2/11/2) and assess for new appliance." LPN #1 was then observed to apply a new colostomy appliance to the excoriated skin surrounding the stoma.  The clinical record of Resident #1  TAG  Different application of the remaindent products and the procedure and stated, at that time, and the procedure and stated at the procedure and stated, at that time, and the procedure and stated, at the p			155723				06/26/2012
RIVER POINTE HEALTH CAMPUS  IN SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  COOLSTOMY care in a sample of 2 residents who met the criteria for colostomy care. (Resident #1)  Findings include:  Hospice Nurse #2 and LPN #1 were observed on 06/18/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. Resident #1 was observed at that time to be grimacing throughout the procedure and stated, "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated.  In an interview at that time, LPN #1 indicated Resident #1 was receiving Diffucan (an oral antifungal medication) for colostomy excoriation. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburgerwhen he goes [has a bowel movement] it just sits on that skin and then it leaks." The Hospice Nurse stated, at that time, "We are gonna come out Thursday (6/21/12) and assess for new appliance." LPN #1 was then observed to the excoriated skin surrounding the stoma.  The clinical record of Resident #1  The clinical record of Resident #1  The clinical record of Resident #1  In the province of the pro	NAME OF A			<del>'</del> T	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
SUMMARY STATEMENT OF DETICIENCIES   PRECEDED BY FULL   PROCEDURES TRANSMIT COMMETTION   PREETX   PROCEDURES TRANSMIT COMMETTION   PREETX   PROCEDURES TRANSMIT COMMETTION   DATE      Colostomy care in a sample of 2   residents who met the criteria for colostomy care. (Resident #1)     Findings include:   Hospice Nurse #2 and LPN #1 were observed on 06/18/12 at 2:52 p.m., providing colostomy care due to leakage to Resident #1. Resident #1 was observed at that time to be grimacing throughout the procedure and stated, "That is so tender!" At that time, the skin surrounding the stoma was observed to be bright red, raised, shiny, and excoriated.   In an interview at that time, LPN #1 indicated Resident #1 was receiving Diffucan (an oral antifungal medication) for colostomy excoriation. LPN #1 stated, at that time, "It's horrible looking, but it did look like hamburgerwhen he goes [has a bowel movement] it just sits on that skin and then it leaks." The Hospice Nurse stated, at that time, "We are gonna come out Thursday (6/21/12) and assess for new appliance." LPN #1 was then observed to experimental was received skin surrounding the stoma. The clinical record of Resident #1    There were no other residents affected by the alleged deficient practice and through corrective acids will esure practice and through carcine will resident #15 colostomy appliance in the resident #1 was receiving Diffucan (and procedure and stated, "That is so tender!" At that time, the skin surrounding the stoma.   The colostomy appliance to the exconiated skin surrounding the stoma.   The clinical record of Resident #1	NAME OF I	PROVIDER OR SUPPLIE	SR .		3001 G	ALAXY DR	
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was reviewed on 6/20/12 at 10:44							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155723		LDING	00	COMPL: 06/26/	
		100720	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	00/20/	2012
NAME OF I	PROVIDER OR SUPPLIER	2			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	a.m. The recordiagnoses includinited to, CVA sided hemipare quarterly MDS Assessment), condicated Residual A Physician's F 06/07/12, indicated Residual and redness around site candidiasis. The Nursing November 7:45 p.m. throup.m. were revied ocumentation physician had be colostomy applifunctioning (lead excoriated skin). A plan of care, hospice include to, intervention signs/symptom such as facial of [complaint of] prestless movement order promptly doctor] and hos discomfort is not as facial of the complaint of	rd indicated the uded, but were not (a stroke) with left esis. The most recent (Minimum Data Set dated 06/07/12, dent #1 had an ostomy.  Progress Note, dated ated, "site at ostomysubstancial [sic] d his ostomyostomy s"  otes from 06/07/12 at 1:00 ewed and lacked any that the attending been notified the liance was not aking) due to the dated 06/18/12, for ed, but was not limited as "observe for its of pain or discomfort, grimacing, c/o pain, moaning or ments and treat per notify MD [medical		TAG	CROSS-REFERENCED TO THE APPROPRIA	TE	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet

Page 11 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
NAME OF B				STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF P	PROVIDER OR SUPPLIEF	C		3001 G/	ALAXY DR		
	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		for skin condition,					
		?, for "irratiation [sic] at					
		h interventions that					
		vere not limited to,					
		changes in skin status,					
		t changes in skin					
	status to MD.						
	A plan of care	for ostomy, dated					
		ded, but was not					
	·	ventions "observe					
	ostomy site da						
		ngnotify physician of					
	any problems						
	arry probleme						
	In an interview	on 6/20/12 at 10:18					
	a.m., with Hos	oice Nurse #1 she					
		ew colostomy supplies					
		are of by the hospice					
		rson on 06/21/12.".					
	In an interview	with LPN #1 on					
	06/22/12 at 9:5	60 a.m., she indicated					
	the colostomy	appliance had been					
	changed daily	"for a couple of weeks"					
		been no change to the					
		my appliance used for					
	Resident #1.	÷ ••					
	In an interview	with the DoN (Director					
	of Nursing) on	06/22/12 at 10:00 a.m.,					
	she indicated t	he physician should					
		was not notified of the					
	· · · · · · · · · · · · · · · · · · ·	e stoma interfering with					
		of the colostomy					
	l	,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY MPLETED 26/2012
	PROVIDER OR SUPPLIER OINTE HEALTH CAMPUS	3001 G	ADDRESS, CITY, STATE, ZIP ALAXY DR SVILLE, IN 47715	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	appliance.				
	3.1-5(a)(2) 3.1-5(a)(3)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

11 F

Facility ID: 002280

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
			_	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	R		GALAXY DR	
RIVER PO	OINTE HEALTH CA	AMPUS		SVILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0167 SS=B	483.10(g)(1) RIGHT TO SUR ACCESSIBLE A resident has the results of the mode facility conducted surveyors and an with respect to the surveyors and an with respect to the surveyors and an with respect to the surveyors and an observed for examination and readily accessible a notice of their and the record review, ensure resident right to review results and the reports for 4 of for knowledge location of surveyors, Resident #8)  Findings included  1. Resident #8 6/21/12 at 9:15 indicated she compared to the surveyors and the recent surveyors. Resident #87 for facility does not meetings and the assistant will consist and surveyors.	very results - readily ne right to examine the est recent survey of the d by Federal or State my plan of correction in effect ne facility.  make the results available and must post in a place le to residents and must post availability.  ervation, interview, and the facility failed to ts were aware of their the most recent survey location of the survey 5 resident interviewed of right to review and erey results (Resident #169, Resident #84,	F0167	F 167  Resident #8, #84, #87 and # have been informed of their right to review the survey results at the location of the survey results and their right to access the survey results and where they are located also.  Completion Date 7-26-12  Activity Director and Admissistaff have been inserviced or resident right to review survey results and through this inservicing will ensure that the are given this information up admission as well as through monthly council meetings.  Completion Date 7-26-12  Activity director will randomly	O7/26/2012  169 right and sults.  ne have feey  ons in the ey  ley on in
<u> </u>	a meeting. Re	sident #87's quarterly		interview 3 skilled residents/v	l l

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Event ID: KFT311

Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155723	B. WIN		-	06/26/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8		3001 G	ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Status) score completed on 5/7/12				rights and information of survey	у
	was 15/15, indicating her long term and short term memory is intact.				results.	
					Results of interviews will be	
	2. Resident #1	69 was interviewed on			forwarded to QA committee	
	6/21/12 at 9:30	a.m. Resident #169			monthly x3 months and	
		lid not know where the			quarterly thereafter for review	w.
		rvey results were kept				
		icated the facility did				
		ent council meetings.				
		_				
	Resident # 169's annual BIMS score for 3/16/12 indicated a 15/15,					
		·				
	_	ong and short term				
	memory is inta	Ct.				
	2 Decident #9	24 was intomiowed an				
		34 was interviewed on				
		a.m. Resident #84				
		d not know where the				
		rvey results were				
		ally did not know the				
		rvey report was				
		sidents. Resident #84				
	indicated he ha	ad not attended a				
	resident counc	il meeting for at least 6				
	months. Resid	lent #84's BIMS score				
	completed on 3	3/26/12 indicated a				
	•	dicated some long and				
	short term men	•				
		Ť				
	4. Resident#	8 was interviewed on				
		0 a.m. Resident #8				
		vas not aware where				
		t survey results were				
		ent # 8 indicated she				
	nad never atter	nded a resident council				

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Event ID: KFT311

Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155723	B. WIN			06/26/	2012
NAME OF I	PROVIDER OR SUPPLIER	· ?	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
DI) (ED D	ONTE LIEALTILO	AMPLIO			ALAXY DR		
RIVERP	OINTE HEALTH C	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE	
		d not know the facility		0			D.II.D
	_	council. Resident # 8					
	indicated she did not what her						
	resident rights	were. Resident #8's					
	BIMS score wa	as completed on					
	3/14/12 and inc	dicated a score of					
	15/15, indicating her long and short						
	term memories	s were intact.					
	Duning as inter	nious with the A.D.					
	1	view with the A.D.					
	1 `	or) on 6/21/12 at 10:15					
	a.m., she indicated the residents were						
		e the most recent					
	survey were lo	cated during their					
	resident counc	il meetings. Resident					
	# 87, Resident	#169, Resident #84,					
	and Resident #	#8 were indicated to					
	have attended	a resident council					
	meeting within	the last 6 months but					
	the residents v	erbally indicated they					
		resident council					
	meetings. The	resident council					
	1	eviewed on 6/20/12 at					
	1:45 p.m. The	minutes lacked any					
	1	that survey results					
		during any resident					
		gs. The minutes					
		cumentation related to					
	-						
		the survey book.					
	The automotion						
	The survey res	sults were observed on					

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Event ID: KFT311

Facility ID: 002280

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number:  155723	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPL 06/26/	ETED
	PROVIDER OR SUPPLIER OINTE HEALTH CAMPUS	STREET A 3001 G	ADDRESS, CITY, STATE, ZIP COD BALAXY DR SVILLE, IN 47715	DE	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
TAG	a table behind the front desk in the lobby on 06/22/12 at 1:30 p.m. In an interview, at that time, the E.D. [Executive Director] indicated the residents were able to access the survey results as the residents come behind the front desk for concerns and issues frequently.  The "Resident Move-in Guide" for residents, obtained on 6/22/12 at 4:00 p.m. for the ED (Executive Director), indicated the residents have a right to examine the most recent survey and the facility's plan of correction.  3.1-3(b)(1)	TAG	DEFICIENCY)		DATE

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Event ID: KFT311

Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X.			(X3) DATE S	SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
	155723				06/26/	2012
				ADDRESS, CITY, STATE, ZIP CODE		
PROVIDER OR SUPPLIER						
OINTE HEALTH CA	MPUS		EVANSVILLE, IN 47715			
SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
483.13(c) DEVELOP/IMPL ETC POLICIES The facility must written policies a mistreatment, ne residents and mi property.  Based on interview, the faci policy and procallegation of the (Resident #73) investigations rensure that ver occur for 1 of 3 reviewed (Resident #83) investigation of versubstantiated at theft was not refindings includ  1. A Resident (02/12/12, was perfectly with Facilities 06/21/12 at 1:0 indicated Resident investigation in not been located investigation larger with the side of the side o	MENT ABUSE/NEGLECT,  develop and implement nd procedures that prohibit glect, and abuse of sappropriation of resident  view and record lity failed to ensure the edure for reporting an eft was followed for 1 of 3 abuse eviewed and failed to bal abuse did not abuse investigations dent #121), in that, an rbal abuse was and an allegation of eported to the police.  e:  Concern Form, dated provided by the HFA es Administrator) on 0 p.m. The report lent #73 had reported esmetic bag with billfold atient states illfold." The dicated the money had ed. The follow-up cked any indication the	F02		Res #73 and #121 no longer reside at the facility. There wer no other residents affected by deficient practice and through training/education will ensure the missing money is reported to the local police and that abuse prevention measures are in place. Completion Date 7-26-12 Administrator will be inserviced on Elder justice act and required notification. Completion Date 7-26-12 All allegations of missing property and abuse will be forwarded to QA committee	the hat he	07/26/2012
	PROVIDER OR SUPPLIER OINTE HEALTH CA  SUMMARY S' (EACH DEFICIEN REGULATORY OR 483.13(c) DEVELOP/IMPLETC POLICIES The facility must written policies a mistreatment, ne residents and mi property.  Based on interview, the faci policy and procallegation of the (Resident #73) investigations rensure that veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation of veroccur for 1 of 3 reviewed (Resident #73) investigation in the first with [sic] passion in the facilities of the first with [sic] passion in the facility of the facility o	OF CORRECTION IDENTIFICATION NUMBER: 155723  PROVIDER OR SUPPLIER  OINTE HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident	PROVIDER OR SUPPLIER  OINTE HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  F02  Based on interview and record review, the facility failed to ensure the policy and procedure for reporting an allegation of theft was followed (Resident #73) for 1 of 3 abuse investigations reviewed and failed to ensure that verbal abuse did not occur for 1 of 3 abuse investigations reviewed (Resident #121), in that, an allegation of verbal abuse was substantiated and an allegation of theft was not reported to the police.  Findings include:  1. A Resident Concern Form, dated 02/12/12, was provided by the HFA (Health Facilities Administrator) on 06/21/12 at 1:00 p.m. The report indicated Resident #73 had reported "missing red cosmetic bag with billfold in it with [sic] patient states \$300-\$400 in billfold." The investigation indicated the money had not been located. The follow-up investigation lacked any indication the	PROVIDER OR SUPPLIER  OINTE HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  F0226  Based on interview and record review, the facility failed to ensure the policy and procedure for reporting an allegation of theft was followed (Resident #73) for 1 of 3 abuse investigations reviewed and failed to ensure that verbal abuse did not occur for 1 of 3 abuse investigations reviewed (Resident #121), in that, an allegation of verbal abuse was substantiated and an allegation of theft was not reported to the police.  Findings include:  1. A Resident Concern Form, dated 02/12/12, was provided by the HFA (Health Facilities Administrator) on 06/21/12 at 1:00 p.m. The report indicated Resident #73 had reported "missing red cosmetic bag with billfold in it with [sic] patient states \$300-\$400 in billfold." The investigation indicated the money had not been located. The follow-up investigation lacked any indication the	PROVIDER OR SUPPLIER  OINTE HEALTH CAMPUS  SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCY MUST BE PERCEDED BY PULL. REGULATORY OR I SC IDENTIFYING INFORMATION)  483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  Based on interview and record review, the facility failed to ensure the policy and procedure for reporting an allegation of theft was followed (Resident #73) for 1 of 3 abuse investigations reviewed and failed to ensure that verbal abuse did not occur for 1 of 3 abuse investigations reviewed (Resident #121), in that, an allegation of verbal abuse was substantiated and an allegation of theft was not reported to the police.  Findings include:  1. A Resident Concern Form, dated 02/12/12, was provided by the HFA (Health Facilities Administrator) on 06/2/11/2 at 1:00 p.m. The report indicated Resident #73 had reported "missing red cosmetic bag with billfold in it with [sic] patient states \$300.5400 in billfold." The investigation lacked any indication the	DENTIFICATION NUMBER: 155723    BUILDING   NUNG   N

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLE	ETED
		155723	B. WIN			06/26/2	2012
			P. (711		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of missing mor	ney.					
		with the HFA (Health					
	Facilities Admi	nistrator) on 06/21/12					
	at 1:00 p.m., sł	ne indicated the police					
	had not been n	otified in regards to the					
	report of missir	ng money.					
		•					
	The Abuse and	d Neglect Procedural					
		vided by the HFA on					
	06/18/12 at 2:15 p.m., indicated, "g. Reportingv. The Elder Justice Act						
		the event that caused					
	•	abuse/neglect resulted					
	•	ly injury, the Executive					
		ignee is required to					
		•					
		picion to the police					
	•	mediately, but not later					
		If the event does not					
	_	injury, it must be					
	reported no lat	er than 24 hours."					
	0 4 - 1 - 1	December 1997					
		Report Form, dated					
	· · · · · · · · · · · · · · · · · · ·	provided by the HFA					
		1:00 p.m. The report					
		legation of verbal					
		de on 02/07/12 at					
		Resident #121. The					
	report further in	ndicated, "Immediate					
	Action taken: I	nvestigation initiated,					
	statements obt	ained during interviews					
	CRCA [Certifie	d Resident Care					
		itted utilizing curse					
	_	onally from stress while					
		e of resident. CRCA					

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Event ID: KFT311

Facility ID: 002280

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	OF CORRECTION  IDENTIFICATION NUMBER:  155723	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED - 06/26/2012		
	PROVIDER OR SUPPLIER POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR  EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION		
	was placed on suspension immediately pending outcome of investigation. Additional witness was found and after completion of investigation it was determined that CRCA violated facility policy. CRCA was termed [terminated] from employment".  In an interview with the HFA on 06/21/12 at 1:00 p.m. she indicated the facility investigation concluded verbal abuse had occurred and the employee was terminated.  The Abuse and Neglect Procedural Guidelines provided by the HFA on 06/18/12 at 2:15 p.m., was reviewed at that time. The facility adhered to the procedural guidelines for the screening, training, prevention, identification, protection, investigation, and reporting of abuse.  3.1-28(a)					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nnia	00	COMPL	ETED
		155723	A. BUII		<del></del>	06/26/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
חויירם חי		MDLIC			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241	483.15(a)						
SS=B	DIGNITY AND R	ESPECT OF					
	INDIVIDUALITY						
		promote care for residents					
		in an environment that ances each resident's dignity					
		Il recognition of his or her					
	individuality.	in recognition of the of their					
	Based on obse	rvation and record	F02	41	F 241		07/26/2012
	review, the faci	lity failed to provide			D #470 #50 #00 L #40		
	meals in a dign	ified manner by yelling			Res #172, #53, #89, and #13 suffered no ill effects from		
	out the names	of residents, when			findings of the 2567L and thro	ıah	
		o identify who the tray			corrective action will ensure th	•	
		3 of 14 residents			dignity is maintained throughout		
		g in the health center			the meal service.		
	` ·	nd by vacuuming in the			Completion Date 7-26-12		
	•	ent during a meal in 1					
		_			All residents have the potentia	l to	
		observed dining in their			be affected by the alleged		
	,	ents #172, #53, #89, &			deficient practice and will have the same dignified meal service		
	#13)				provided through corrective		
					actions.		
	Findings includ	e:			Completion Date 7-26-12		
	1 During the li	unch meal observation			In-service for all staff that assis	st	
	_	2:28 p.m., MDS			with meal service to include ta		
		•			service process. In-service for		
	•	Set Assessment)			housekeeping regarding		
		yelled out Resident #			appropriate activity during the		
		three times until			dining process.		
		raised her hand.			Completion Date 7-26-12		
	MDS Coordinat	tor #1 then delivered			Executive Director/designee w	ill	
	the tray to Resi	dent #172. During			monitor 2 random meals per d		
	that same mea	I CRCA (Certified			x2 weeks, 1 random meal per		
	Resident Care	Associate) #2 was			x2 weeks, 2 random meals pe	-	
		g out Resident #53's			week x 2 months, then 2 rando	om	
	_	es with no answer.			meals per month thereafter.		
		ned the tray to the cart.					
	One menifican	ica the tray to the cart.			Results of audits will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
NAMEOUR	DOMDED OF GLIDE IEI		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	X	3001 G	ALAXY DR	
RIVER P	OINTE HEALTH C	AMPUS	EVANS	SVILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		tor #1 was then		reported to QA committee	
		ll out Resident #89's		monthly x6 months and then quarterly.	
		sident's family member		quarterly.	
	then stated "ov	er here" and CRCA #2			
	delivered the to	ay to Resident #89.			
	· •	ed by the Administrator			
	on 6/22/12 at 1	0:00 a.m., and titled			
	Resident Move	e-in Guide with no			
	reference date	, indicated the facility			
	would honor a	nd assist with the			
	resident's right	to maintain			
	"independent f	unctioning, dignity, and			
	well-being."	·			
		s observed to deliver			
		lunch at 12:25 p.m.,			
		d then left the room.			
	· ·	per then entered the			
	·	in the vacuum cleaner,			
		vas going to vacuum			
		roceeded to vacuum			
	her lunch.	the resident was eating			
	neriunen.				
	The Administra	ator and Director of			
		ed, on 6/18/12 at 5:30			
		,			
	l •	ekeeper should not			
		d the floor while the			
	resident was e	aung lunch.			
	24.24				
	3.1-3(t)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 22 of 101

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
		155723	A. BUILDING B. WING	<del></del>	06/26/2012		
NAME OF B	DOWNER OF CURRING			ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIEI		3001 GALAXY DR				
RIVER P	OINTE HEALTH CA	AMPUS	EVANS	VILLE, IN 47715			
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE		
TAG	REGULATORT OF	CESC IDENTIF THY INFORMATION)	IAG		DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 23 of 101

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIG	00	COMPL	ETED
		155723		A. BUILDING B. WING		06/26/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
חויירם חי		MDUIC			ALAXY DR		
RIVERP	OINTE HEALTH CA	MINIPUS		EVAINS	VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0242	483.15(b)						
SS=D		NATION - RIGHT TO MAKE					
	CHOICES						
		the right to choose					
		ules, and health care					
		is or her interests,					
		d plans of care; interact with community both inside and					
		y; and make choices about					
		her life in the facility that are					
	significant to the	•					
	organicant to the	100.00110.	F02	42	F 242		07/26/2012
	Danad an abaa		102	12	1 272		07/20/2012
		rvation, interview, and			Resident #1 has his preference	es	
		the facility failed to			documented and careplanned		
	ensure residen	t choices were			accordingly.		
	honored for hav	ving a shower for 1 of			Completion Date 7-26-12		
	2 residents who	met the criteria for					
	choices. (Resid	dent #1)			Staff that care for Res #1 have	;	
	(	20			been inserviced on his		
	Eindings inslud	0.			preferences and plan of care.		
	Findings includ	e.			Completion Date 7-26-12		
	The ellers of a	and of Dooids at #4			There were no other residents		
		ord of Resident #1			affected and through inservicir		
		on 6/20/12 at 10:44			and obtaining preferences will	ıy	
	am. The record	d indicated the			ensure those who want a show	ver	
	diagnoses inclu	ided, but were not			receive it.	. 5.	
	limited to, Cere	brovascular Accident			Completion Date 7-26-12		
		eft sided hemiparesis.			•		
	(======================================				Systemic change is that bathir	ng	
	In a family inter	view on 06/19/12 at			preference will be entered into		
	•				resident profile on caretracker.		
		spouse of Resident #1			Completion Date 7-26-12		
	•	nts to take a shower			<u> </u>		
	and it takes thre	ee people to shower			Nursing staff will be inserviced		
	him, so he has	only had a bedbath for			resident profile procedure and		
	the last two mo	nthsThey don't have			preferences.		
		for people like			Completion Date 7-26-12		
	[Resident #1's				DHS/designee will monitor 3		
	Li Condont #13				residents bathing preferences	ner	
			1		l residents battiling preferences	PCI	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 24 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155723	B. WIN	IG		06/26/2012		
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
TWINE OF T	NO VIDEN ON SOLVEIEN				ALAXY DR			
RIVER P	OINTE HEALTH CA	AMPUS		EVANSVILLE, IN 47715				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE		
	Resident #1 wa	as observed on			day x2 weeks ,3 per week x2			
	06/19/12 at 9:00 a.m., to be lying in				months and 3 per month thereafter to ensure care is			
	bed. In an interview, at that time,				reflective of resident preference	e l		
	Resident #1 ind	dicated he would like to			remediate of resident preference			
	take a shower.				Results of audits will be			
					provided to QA committee			
	In an interview	with CRCA (Certified			monthly for review x6 month	s		
	Resident Care	Associate) Preceptor			and quarterly thereafter.			
	on 06/20/12 at	10:56 a.m., she						
	stated, "I gave	[Resident #1] a partial						
	bath this morni	ng before breakfast."						
	The CRCA Pre	ceptor further						
	indicated Resident #1 was not able to take a shower.							
	In an interview	with CRMA (Certified						
		cation Associate) #1 on						
		29 a.m., she indicated						
	Resident #1 re							
		dbaths, but he was not						
		shower because he						
	leans in the cha							
	In an interview	with MDS (Minimum						
		ssment) Coordinator #1						
		10:22 a.m., she stated						
		does not get a shower						
		nability to stay properly						
		e shower chair, if he						
	· ·	rer [Resident #1] could						
		to the spa on the						
		The MDS Coordinator						
	-	that time, a Bathing						
	-	at indicated Resident						
	#1 had not rece	eived a shower or full						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

If continuation sheet

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155723	A. BUILDING	00	COMPLETED 06/26/2012
		100720	B. WING	T ADDRESS CITY COATE OF COATE	00/20/2012
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE GALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS		ISVILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	BEIGERCI)	DATE
	bath in the last	30 days.			
	Resident #1, reidentified a prodeficit "needs a dependent in interventions the not limited to, hygiene as need amount of assis is needed with Daily Living]"				
	shower.				
	Conference No lacked any doc	lacked any			
	of Nursing) on she indicated the self-care deficit	with the DoN (Director 06/22/12 at 10:00 a.m., ne plan of care for ADL did not address the to receive a shower.			
	dated 06/07/12 experienced m	nt quarterly MDS, , indicated Resident #1 oderate cognitive quired extensive			

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Event ID: KFT311

Facility ID: 002280

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AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155723	A. BUILDING B. WING		06/26/2012		
NAME OF PROV	VIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
RIVER POIN	ITE HEALTH CA	MPUS	3001 GALAXY DR EVANSVILLE, IN 47715				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG		vo staff for bathing and	TAG	BEIGHNOT	DATE		
	ersonal hygier						
Du 06 #1 tra tha wa Th to pe tha ind lea	uring an obser 6/21/12 at 11: 1 and CRMA # ansfer Resident as experiencing the Hospice CN o give Resident ersonal bathronal time, the Hospice	rvation of care of 13 a.m., Hospice CNA  21 were observed to 13 a.m., Hospice CNA 14 were observed to 15 ir. In an interview at 16 ir. In an interview at 16 ir. In an interview at 17 indicated he 18 pain in his left arm. 18 NA #1 was observed 18 t #1 a shower in his 19 ir. In an interview at 19 ir. In an interview at 19 ir. In an interview at 19 ir. In an observed him to					

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Event ID: KFT311

Facility ID: 002280

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  06/26/2012
	PROVIDER OR SUPPLIE		3001 G	ADDRESS, CITY, STATE, ZIP CODE GALAXY DR SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0246 SS=D	NEEDS/PREFE A resident has t services in the f accommodation preferences, ex	ACCOMMODATION OF RENCES he right to reside and receive acility with reasonable s of individual needs and cept when the health or safety or other residents would be	F0246	F 246	07/26/2012
	record review, ensure a resid shower was pr accommodatic for 1 of 3 resid	ervation, interview, and the facility failed to ent who wanted a covided with reasonable ens to receive a shower ents who met the vities of Daily Living.		Resident #1 has his preference documented and careplanned accordingly.  Completion Date 7-26-12  Staff that care for Res #1 have been inserviced on his preferences and plan of care.  Completion Date 7-26-12	
	was reviewed a.m. The reco diagnoses incl limited to, CVA	de: cord of Resident #1 on 6/20/12 at 10:44 rd indicated the uded, but were not a (Cerebrovascular roke) with left sided		There were no other residents affected and through inservicin and obtaining preferences will ensure those who want a show receive it.  Completion Date 7-26-12  Systemic change is that bathin preference will be entered into resident profile on caretracker Completion Date 7-26-12	ng wer
	8:54 a.m., the stated, "He wa and it takes thin him, so he has the last two mo	rview on 06/19/12 at spouse of Resident #1 ints to take a shower ree people to shower only had a bedbath for onthsThey don't have nfor people like		Nursing staff will be inserviced resident profile procedure and preferences.  Completion Date 7-26-12  DHS/designee will monitor 3 residents bathing preferences day x2 weeks ,3 per week x2 months and 3 per month	

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Event ID: KFT311

Facility ID: 002280

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED
		155723	B. WIN		-	06/26/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			3001 G/	ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS		EVANS'	VILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	[Resident #1]."				thereafter to ensure care is reflective of resident preference	
					Tellective of resident preference	.e.
	Resident #1 wa				Results of audits will be	
	06/19/12 at 9:0	0 a.m. to be lying in			provided to QA committee	
	bed. In an inte	rview, at that time,			monthly for review x6 month	s
	Resident #1 ind	dicated he would like to			and quarterly thereafter.	
	take a shower.					
	In an interview	with CRCA (Certified				
		Associate) Preceptor				
		10:56 a.m., she				
		lent #1 was not able to				
	take a shower.	ient #1 was not able to				
	lake a shower.					
	In an interview	with CDMA (Cortified				
		with CRMA (Certified				
		cation Associate) #1 on				
		29 a.m., she indicated				
	Resident #1 re	·				
		dbaths, but he was not				
	able to take a s	shower because he				
	leans in the cha	air.				
	In an interview	with MDS (Minimum				
	Data Set Asses	ssment) Coordinator #1				
	on 06/21/12 at	10:22 a.m., she stated				
	"[Resident #1]	does not get a shower				
		ability to stay properly				
		e shower chair, if he				
	· ·	er [Resident #1] could				
		to the spa on the				
		The MDS Coordinator				
	•	that time, a Bathing				
		at indicated Resident				
		eived a shower or full				
	bath in the last	30 days.				

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/26/2012
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE SALAXY DR	
RIVER F	POINTE HEALTH C	AMPUS	EVANS	SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TTATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Resident #1 or a.m., she indict knowledge of a floor and that a shower had need the floor and that a shower had need the floor and that a shower had need the floor and that a shower th	with the spouse of n 06/21/12 at 10:45 ated she had no a spa on the second an alternative to a ever been offered.  ent care plan for evised on 03/30/12 ablem of self-care g with interventions that ever not limited to, ersonal hygiene as e plan of care did not oncerns with the eing able to take a ent Resident First otes, dated 05/03/12,			
	lacked any doc concerns, osto nursing issues summary area documentation In an interview of Nursing) on she indicated t (Activities of D deficit had not address the ne	cumentation of skin my site concerns, or . The meeting lacked any			

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Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 30 of 101

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155723	B. WIN			06/26/	2012
	PROVIDER OR SUPPLIER			3001 G	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR SVILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	The most recer dated 06/07/12 experienced mimpairment, an assistance of topersonal hygie.  During an obseto 06/21/12 at 11: #1 and CRMA transfer Reside the shower chart time, Reside was experienci. The Hospice C to give Resider personal bathrothat time the Hospical control of the Hospical cont	nt quarterly MDS, indicated Resident #1 oderate cognitive d required extensive wo staff for bathing and ne. ervation of care of 13 a.m., Hospice CNA #1 were observed to ent #1 from the bed to air. In an interview at dent #1 indicated he ng pain in his left arm. NA #1 was observed nt #1 a shower in his com. In an interview at ospice CNA #1 ve not observed him to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KFT311

Facility ID: 002280

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155723	B. WIN			06/26/2012
			D. 1711		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS	EVANSVILLE, IN 47715			
(X4) ID		FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	, The state of the	CY MUST BE PERCEDED BY FULL				TE COMPLETION DATE
F0253		LSC IDENTIFYING INFORMATION)	-	IAG	DLI ICILIACI )	DATE
SS=B	483.15(h)(2)	G & MAINTENANCE				
33-D	SERVICES	O & MAINTENANCE				
		provide housekeeping and				
		vices necessary to maintain				
	a sanitary, order	y, and comfortable interior.				
			F02	53	F 253	07/26/2012
	Based on obse	rvation, record review				
		he facility failed to			There were no residents affect	ted
	1	eeping services to			by	
	l ·	free room for 1 of 39			this deficiency.	
					Res # 84's room has been	
		ng in the facility			cleaned and carpet has been	
	` ′	and failed to ensure			shampooed.	
		e of marred walls for 6			Completion Date 7-26-12	
	of 39 residents	residing in the facility.			•	
	(Resident #5, F	Resident #163,			Res #5, #163, #168, #173, #1	
	Resident #168,	Resident #173,			and #176 rooms have had rep	
	Resident #174,	Resident #176)			including bathrooms and doors	3.
		•			Completion Date 7-26-12	
	Findings includ	e:			Housekeeping supervisor will	
					audit 3 rooms/day for 2 weeks	3
	1 Observation	of Resident #84's			rooms/week for 2 months and	
		room indicated a			rooms/month thereafter.	
					Completion Date 7-26-12	
	_	or for the following				
	dates and times				Executive Director will receive	
	- 6/19/12 at 10:				audit and monitor completion	
	- 6/19/12 at 2:3	•			of projects/cleaning schedule	
	- 6/20/12 at 9:0				for timeliness and report to C	
	- 6/20/12 at 1:5	5 p.m.			committee on a monthly basi	IS
	- 6/21/12 at 7:3	0 a.m.			the status of building.	
	- 6/21/12 at 2:5	5 p.m.			QA committee will review the	
	- 6/22/12 at 7:5	•			building condition report	
					monthly x12 months.	
	Observation on	6/22/12 at 7:55 a.m.,				
		,				
		newspaper on the				
	resident's floor	in his room which was	1			

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Event ID: KFT311

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155723	B. WIN	G		06/26/2	2012
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DIVED D		MPUO	3001 GALAXY DR EVANSVILLE, IN 47715				
RIVERPO	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	stuck to the car	pet.					
	6/21/12 at 7:50 indicated the st changing his cle him to the bath.  Interview with H. Nurse Aide) #1 a.m., indicated urine frequently.  Record review p.m., indicated Data Survey), condicated Resident	Hospice CNA (Certified on 6/22/12 at 10:22 the resident "dribbles" /. on 6/22/12 at 1:15 the MDS (Minimum					
	observed on 6/ The walls were marks.  3. Resident # 7 observed on 6/ The walls were marks.  4. Resident # 7 observed on 6/ The walls were marks and gour	168's room was 18/12 at 3:00 p.m. marred with black  163's room was 19/12 at 8:45 a.m. marred with black  173's room was 19/12 at 2:25 p.m. marred with black ged.					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  155723	(X2) MULTIPLE CO A. BUILDING B. WING	00		LETED 5/2012
	PROVIDER OR SUPPLIER OINTE HEALTH CAMPUS	3001 G	ADDRESS, CITY, STATE, ZIP ALAXY DR SVILLE, IN 47715	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	observed on 6/19/12 at 9:48 a.m. The bathroom door had large black marks.				
	6. Resident # 176's room was observed on 6/19/12 at 10:50 a.m. The walls were marred along a section one foot above the floor.				
	7. Resident # 5's room was observed on 6/19/12 at 10:03 a.m. The walls were marred throughout with black marks.				
	3.1-19(f)				

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Event ID: KFT311

Facility ID: 002280

If continuation sheet

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER				
		AMPLIC		ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS	EVANS	VILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0272	483.20, 483.20(b	0)			
SS=D	COMPREHENSI	IVE ASSESSMENTS			
	The facility must	conduct initially and			
	periodically a cor	mprehensive, accurate,			
	standardized reproducible assessment of				
	each resident's f	unctional capacity.			
	A facility must make a comprehensive assessment of a resident's needs, using the				
		the State. The assessment			
		east the following:			
	Customary routir	d demographic information;			
	Cognitive pattern				
	Communication;				
	Vision;				
	Mood and behav	vior patterns:			
	Psychosocial we				
	•	ning and structural problems;			
	Continence;	,			
	Disease diagnos	is and health conditions;			
	Dental and nutrit	ional status;			
	Skin conditions;				
	Activity pursuit;				
	Medications;				
		nts and procedures;			
	Discharge poten				
		of summary information			
		ditional assessment			
		gh the resident assessment			
	protocols; and	of participation in			
	Documentation of	or participation in			
	assessment.		E0272	F 070	07/26/2012
		rvation, interview, and	F0272	F 272	07/26/2012
	record review,	the facility failed to		Res #20 had a modification do	ino.
	ensure MDS (M	/linimum Data Set)		to the MDS and was a closed	IIC
	assessments w	ere accurate, and		record thus no longer resides i	n
		irrent condition for 1 of		the facility.	"
		esident #20) reviewed		Completion Date 7-26-12	
	,	•			
	ior pressure ulo	cers in the sample of		Res #163 no longer resides at	the
				123 # 155 # 151 # 151 # 155	

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Event ID: KFT311

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155723	B. WIN			06/26/2012	
			J. 11 II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	the 3 who met	the criteria and for 1 of			facility and through corrective		
	3 residents (Re	esident #163) reviewed			action of dental questionnaire		
	for dental statu	s in the sample of 3			will ensure any resident with il fitting dentures will be		
	who met the cr	iteria.			documented.		
					Completion Date 7-26-12		
	Findings Includ	le·					
					Social service and nursing		
	1 Pecord rovi	ew on 6/21/12 at 3:00			inserviced on dental		
					questionnaire to be done for a		
	· ·	ent #20's closed record			new admissions and with each	۱	
		esident had entered the			full MDS assessment.		
	facility on 4/12/	12.			Completion Date 7-26-12		
	A da a	ad Oliva Iranasirras and			MDS nurses inserviced on coo	ding	
		ed Skin Impairment			of pressure ulcers.	-	
		nvestigation, dated			Completion Date 7-26-12		
	· ·	ted Resident #20 had a					
	left heel pressu	ıre area stage 1, with			Systemic change is that Socia	l	
	possible deep t	tissue injury.			Service will keep a log of all residents with dental concerns		
					and coordinate/document folic		
	A document titl	ed			up accordingly.	···	
	"Pressure/Stas	is/Arterial/Diabetic			Completion Date 7-26-12		
		ent," dated 4/30/12,					
		dent #20 had a left heel			DHS/designee will review		
		with suspected deep			validation reports of MDS's		
	· .	d not present on			submitted weekly to ensure th	•	
	, ,	been circled. The			residents with pressure ulcers		
					have been coded and modification done immediately	, if	
	•	was described as a 3.0			incorrect.	"	
	`	) in length by 3.0 cm in					
		depth was unable to be			Results of all audits and den	tal	
		n 5/1/12, the pressure			log will be forwarded to QA		
	area was desci	ribed as 3.0 cm in			committtee monthly x6 mont	hs	
	length by 3.0 c	m in width, and staged			and quarterly thereafter.		
	as an E (unsta	geable). The current					
	treatment was	Skin Prep to the heel,					
		e used to lift the heel					
		id no shoes. On					
						ĺ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		3001 G/	ALAXY DR		
RIVER P	OINTE HEALTH CA			EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	``	CROSS-REFERENCE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	· ·	ssure area to the left					
		ribed as a 2.2 cm in					
	length by 2.0 cm in width and staged as an E. The treatment was to apply Optifoam (a pressure ulcer treatment) every other day, Z flow, and no shoes.						
	A Minimum Da	ta Set Assessment					
		5/1/12, coded the					
	, , , , , , , , , , , , , , , , , , ,	·					
	resident as being at risk for developing pressure ulcers but did not have any pressure areas coded at						
	the time.	resears areas sousa at					
	the time.						
	In an interview	with the DoN (Director					
		06/21/12 at 3:30 p.m.,					
	J – – – – – – – – – – – – – – – – – – –	she did not know how					
		e injury could have					
	•	Z flow device had					
	been used.						
		63 was interviewed on					
		a.m. She indicated					
		ures) had been loose					
	,	weight. She indicated					
		osing weight since her					
		ast year. The teeth					
		, during breakfast at					
		. •					
		moving around in the					
	resident's mou	uı.					
	Resident #163	's clinical record was					
		21/12 at 4:07 p.m. The					
		imum Data Set (MDS)					
		ated 5/21/12, indicated					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155723	A. BUILDING	00	06/26/2012
		100720	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/20/20 12
NAME OF F	PROVIDER OR SUPPLIE	₹		ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS		VILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	the resident ha	d no dental problems.			
	3.1-31(a)				
	,				

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Event ID: KFT311

Facility ID: 002280

If continuation sheet Page 38 of 101

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
E OF P			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		3001 G	ALAXY DR	
RIVER P	OINTE HEALTH CA	MPUS	EVANS	SVILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0279 SS=D	PLANS A facility must us assessment to d	PREHENSIVE CARE se the results of the evelop, review and revise the ehensive plan of care.			
	care plan for each measurable object meet a resident's mental and psycidentified in the compart of the care plan mare to be furnished resident's highest mental, and psycinequired under § that would other §483.25 but are resident's exercise	develop a comprehensive the resident that includes ctives and timetables to a medical, nursing, and thosocial needs that are comprehensive assessment.  Sust describe the services that the deto attain or maintain the practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, at to refuse treatment under			
	Based on obse	rvation, interview, and	F0279	F 279	07/26/2012
	ensure care pla and revised, in a shower and e from his coloste issues were no plan of care (Re residents review criteria for colos residents review	the facility failed to ans were developed that a resident wanted experienced leakage omy appliance and the t addressed on the esident #1) for 1 of 2 wed who met the stomy care and 1 of 3 wed who met the vities of Daily Living. e:		Resident #1 has careplan updated to reflect shower/bath interventions and current osto appliance.  Completion Date 7-26-12  There were no other residents affected and through inservicin will ensure residents with ostomies have updated carepl and those residents that are unable to take showers have a plan of care reflective of interventions.  Completion Date 7-26-12	my s ng lan

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Event ID: KFT311

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED	
		155723	A. BUI B. WIN			06/26/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ALAXY DR		
DIVED D	OINTE HEALTH CA	AMDUS			VILLE, IN 47715		
		AWI 03		LVANO	· · · · · · · · · · · · · · · · · · ·		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	The clinical rec	cord of Resident #1			Nursing staff will be inserviced	lon	
	was reviewed	on 6/20/12 at 10:44			alternatives to showers and	.11	
	a.m. The record indicated the diagnoses included, but were not limited to, CVA (Cerebrovascular				documentation of ADL's as we as ostomy careplanning.		
					Completion Date 7-26-12		
		roke) with left sided			DHS/designee will review ADL	_	
	, ,	The most recent			report and ostomy careplans		
	•	(Minimum Data Set			3x/week for 2 months, weekly		
		dated 06/07/12,			2 months and monthly thereaf	ter.	
	· · · · · · · · · · · · · · · · · · ·						
		dent #1 experienced			Completion Date 7-26-12		
		nitive impairment,			Describe of audite will be		
	required extens	sive assistance of two			Results of audits will be forwarded to QA committee		
	staff for bathing	g and personal			monthly x6 months and		
	hygiene.				quarterly therafter.		
					quarterly incruiter.		
	1. In a family i	nterview on 06/19/12 at					
	1	spouse of Resident #1					
		nts to take a shower					
		ree people to shower					
		only had a bedbath for					
		•					
		onthsThey don't have					
		for people like					
	-	Resident #1 was					
		t that time to be lying in					
	bed on his bac	k.					
	In an interview	with CRCA (Certified					
	Resident Care	Associate) Preceptor					
		10:56 a.m., she					
		dent #1 was not able to					
		because he leaned in					
	the shower cha						
	i ile shower cha	য়। .					
		With ODMA (C. US. I					
		with CRMA (Certified					
	Resident Care	Associate) #1 on					

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Event ID: KFT311

Facility ID: 002280

If continuation sheet

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
	155723	A. BUILDING		06/26/2012
		B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF I	PROVIDER OR SUPPLIER		ALAXY DR	
RIVER P	OINTE HEALTH CAMPUS	EVANS	VILLE, IN 47715	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	NATE COM ELITOR
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	06/21/12 at 11:29 a.m., she indicated			
	Resident #1 received hospice services for bedbaths, but he was not			
	able to take a shower because he			
	leans in the chair.			
	leans in the orian.			
	In an interview with MDS Coordinator			
	#2 on 06/21/12 at 10:22 a.m., she			
	stated, "[Resident #1] does not get a			
	shower related to his inability to stay			
	properly positioned in the shower			
	chair, if he desired a shower			
	[Resident #1] could be brought up to			
	the spa on the second floor. The			
	MDS Coordinator #2 provided, at that			
	time, a Bathing Detail report that			
	indicated Resident #1 had not			
	received a shower or full bath in the last 30 days.			
	last 50 days.			
	The most current care plan for			
	Resident #1, revised on 03/30/12,			
	identified a problem of self-care			
	deficit"needs assistance or is			
	dependent in bed mobility,personal			
	hygiene, bathing with interventions			
	that included, but was not limited to,			
	assist with personal hygiene as			
	needed" The plan of care did not			
	address any concerns with the			
	resident not being able to take a			
	shower.			
	In an interview with the DoN (Director			
	of Nursing) on 06/22/12 at 10:00 a.m.,			
	01 140131119) 011 001221 12 at 10.00 a.111.,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/26/2012	
	PROVIDER OR SUPPLIE		STREET A	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	been revised a	the plan of care had not and did not reflect the t able to take a shower.			
	were observed p.m., providing leakage to Rest the skin surrout observed to be shiny, and excurat that time, LF Resident #1 w (an oral antifur colostomy excurated, at that [has a bowel in that skin and the skin and the was then observed to be colostomy approximated of the skin surrounding that skin surrounding the status to MD, cream as order lacked any door revising the type appliance used	for skin condition, 2, for "irratiation [sic] at th interventions that were not limited to, changes in skin status, at changes in skinprotective barrier red. The plan of care cumentation related to			

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Event ID: KFT311

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155.722			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155723	B. WIN			06/26/	2012
NAME OF P	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG	03/23/12, included limited to intervostomy site dain redness/swelling any problems lacked any documentation limited to intervostomy site dain redness/swelling any problems lacked any documentation lacked any documentation limited li	ded, but was not rentions "observe ly for agnotify physician of". The plan of care umentation related to be of colostomy l.  Int Resident First stes, dated 05/03/12, umentation of skin my site concerns, or The meeting lacked any		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		(X2) MULTIPLE  A. BUILDING	(X3) DATE SURVEY  COMPLETED		
		155723	B. WING		06/26/2012
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR  EVANSVILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0282 SS=E	CARE PLAN The services pro facility must be p	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons with each resident's written	F0282	F 282	07/26/2012
			10282	F 202	07/20/2012
	record review, ensure service accordance wit of 21 residents the plan of care did not receive preventive mea Resident #20 a not receive premeasures accordance with the plan of care did not receive premeasures accordance.	the facility failed to s were provided in the plan of care for 3 reviewed for following e, in that Resident #1 personal care and asures for pain, and Resident #88 did essure prevention ording to the plan of t #1, Resident #20, and		Res #1 has current interventifor pain and personal care beindelivered per plan of care and staff that care for him have beinserviced.  Completion Date 7-26-12  Resident #20 and #88 were closed records but through inservicing and monitoring will ensure plan of care for pain an pressure prevention are carried out.  Completion Date 7-26-12	ng en
	Findings includ			Systemic change is the floatin heels being placed on the TAI for nurses to validate.  Completion Date 7-26-12	
	was reviewed of a.m. The recordiagnoses including limited to, CVA Accident) (a strangement of the strangemen	record of Resident #1 on 6/20/12 at 10:44 rd indicated the uded, but were not a (Cerebrovascular roke) with left sided  dated 03/30/12, for t, "needs assistance or		Inservice for nursing staff relator pressure prevention and paramanagement.  Completion Date 7-26-12  DHS/Designee will monitor all TAR's and pain logs 5x/week 4 weeks, 2x/week for 12 week and weekly thereafter for prop documentation.	for (S,
	is dependent irpersonal hyg	i bed mobility, iene,assist with		Results of monitoring will be forwarded to QA committee	

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Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155723	B. WIN			06/26/2012
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER				ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	,	DATE
	ı .	ne as needed including			monthly x6 months and quarterly thereafter for review	
	· ·	and repositionevery			and further recommendation	
	hour while in bed/chairleft arm sling when up"					
	Δ plan of care	dated 06/18/12, for				
	1	ed, but was not limited				
	to, intervention					
	· ·	is of pain or discomfort,				
	such as facial	•				
	· `	pain, moaning or				
		nents and treat per				
		, notify MD [medical				
	doctor] and hos					
	_	ot alleviated by current				
		atment regimen"				
	medication tree	aunonerogimon				
	A plan of care	for skin condition,				
	1	, for "irratiation [sic] at				
	stoma site" witl	h interventions that				
	included, but w	vere not limited to,				
	assess/record	changes in skin status,				
	report pertinen	t changes in skin				
	status to MD,	protective barrier				
	cream as order	red.				
	A plan of care	•				
		tified a problem of				
		th interventions that				
		vere not limited to,				
	,	eft arm sling when up,				
	administerprr					
		he plan of care				
		ditional intervention,				
	dated 06/20/12	2, for "offer pain meds				

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Event ID: KFT311

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
RIVER P	OINTE HEALTH C	AMPUS		GALAXY DR SVILLE, IN 47715	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	after care"	as needed before and			
	03/23/12, including limited to interpostomy site data.	ngnotify physician of			
	Conference No lacked any do- concerns, osto	-			
	(Minimum Dat dated 06/07/12 experienced m impairment, re	ent quarterly MDS a Set Assessment), 2, indicated Resident #1 noderate cognitive equired extensive two staff for bathing and ene.			
	Assignment sh was provided on 06/18/12 at Assignment S #1 required "s night, required for hygiene an	tified Nursing Assistant) neet, dated 06/13/12, by the Regional Nurse t 12:10 p.m. The heet indicated Resident plint to right hand at I extensive assistance d grooming, was to bed, was a wound risk,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	
חוייבה ה	OINTE LIEALTIL O	AMDUC		GALAXY DR	
RIVERP	OINTE HEALTH CA	AMPUS	EVAN	SVILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
TAG		turned every two	TAG		DAIL
		d colostomy care every			
	shift, Gerisleeves at all times, splint left arm when up"				
		ap			
	Resident #1 wa	as observed on			
		00 p.m., to be lying in			
		k with his buttocks on			
	the mattress. F	Resident #1 was			
	observed to no	t have gerisleeves on			
	his arms and h	is heels were observed			
	to be lying on t	he mattress.			
		as observed on			
		52 p.m., to be lying in			
		k with his buttocks on			
		Resident #1 was			
		t have gerisleeves on			
		is heels were observed			
		he mattress. In an			
		at time, LPN #1			
		dent #1 was to be vo hours because he			
		for skin breakdown.			
		en observed to tilt			
		shoulder to the right			
		a pillow behind his			
	upper back. Re	•			
		ive his buttocks and			
	heels lying on				
	la a facette to t	min on 00/40/40 -4			
		rview on 06/19/12 at			
		spouse of Resident #1			
		nad never seen the			
	staπ provide or	al care to Resident #1.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
			J. 1711		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	She further ind	icated she had					
	provided oral care to Resident #1 on the previous day.						
	'						
	Resident #1 w	as observed on					
	06/19/12 at 9:00 a.m., lying in bed						
		lers positioned to the					
	right with a pillo	-					
		his buttocks on the					
		ident #1 was observed					
	_	risleeves on his arms,					
		observed lying on the					
		he was observed to					
	have a foul mo	uth odor.					
	Resident #1 wa	as observed on					
	06/19/12 at 10:	:00 a.m., lying in bed					
		ers positioned to the					
		ow behind his shoulder					
		s on the mattress.					
		as observed to not					
		es on his arms and his					
		served lying on the					
	mattress.						
		as observed on					
	06/19/12 at 11:	:15 a.m., sitting upright					
	in a wheelchair	r. Resident #1 was					
	observed, at th	at time, to not have					
		his arms and was					
	~	ot have a sling on his					
	left arm.	A THE FO A CHING ON THE					
	icitalli.						
	Dooident #4 ····	an abanmad ar					
		as observed on					
	06/19/12 to hav	ve no pressure relief to	$\perp$				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155723	B. WIN			06/26/2	2012
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			DDRESS, CITY, STATE, ZIP CODE		
חויירם ה	OINTE LIEALTH O	AMPLIO			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION DATE
TAG	his bottom for two hours and 15			TAG	Birtelinery		DATE
	minutes.	wo flours and 15					
	minutes.						
	Resident #1 wa	as observed on					
		45 a.m., in the main					
	lobby at a mus	•					
	1	and foul mouth odor.					
		as observed to not					
		es on his arms or a					
	sling to his left						
	Resident #1 wa	as observed on					
	06/20/12 at 11:	53 a.m., sitting in a					
		dining room table.					
		as observed to not					
	have gerisleeve	es on his arms or a					
	sling to his left						
	In an interview	with CRMA (Certified					
	Resident Medic	cation Associate) #1 on					
	06/20/12 at 1:3	0 p.m., she indicated					
	CRCA Precept	or had "just put him					
		ack to bed about 1:15					
		t #1 was observed, at					
	· ·	lying in bed on his					
		uttocks and his heels					
	on the mattress	S.					
	Resident #1 wa						
		0 p.m., lying in bed					
		and heels on the					
	mattress.						
	Danisla at 44	ala musad					
	Resident #1 wa						
	06/20/12 to hav	ve no pressure relief to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		A. BUILDIN		NSTRUCTION 00	(X3) DATE ( COMPL <b>06/26</b> /	ETED	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	00/20/	2012
RIVER P	OINTE HEALTH CA	MPUS	E'	VANS\	/ILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		FIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	his bottom for 4 minutes.	hours and 10					
		as observed on 0 a.m., lying in bed d heels lying on					
	Resident #1 was observed on 06/21/12 at 9:15 a.m., sitting in bed with the head of bed elevated eating breakfast.  Resident #1 was observed on 06/21/12 at 11:06 a.m., lying in bed on his back with his bottom and heels lying on the mattress.						
	shower chair ta	13 a.m., sitting in a king a shower. At that area of pressure was					
		15 p.m., lying in bed h his bottom and heels					
	Data Set Asses on 06/21/12 at indicated, oral	with MDS (Minimum sement) Coordinator #1 10:22 a.m., she care should be ersonal hygiene.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/26/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	#20 on 6/21/12 the resident wa facility on 4/17/ "Nursing Admis Collection, date indication of a I and the skin pla and reposition prevent skin fro lift sheet to report sure relieve bed, explain coof treatment an interventions, a clean and dry. Admission Asso Collection document witten note in dated 4/30/12 a float left heel, reskid socks."  A care plan title dated 4/26/12 a 6/1/12 indicated risk for skin are extremities due such as: histor wound infection included but we assess skin sta pressure to are	essment Data Iment included a hand the margin which was and said, "Z float to to shoes, wear non  ed skin condition and with a review date of the resident was at the as on lower to disease process y of cellulitis and the interventions the not limited to tus and prevent					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
NAME OF F	DROWDER OF CURRENTE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF			3001 G	ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS'	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
		, dated 4/30/12 and					
	reviewed 6/1/12, indicated interventions including but not limited to Z flow to float left heel, no shoes, wear non skid socks, monitor						
		of pressure relieving					
	devices.	n pressure relieving					
	devices.						
	A treatment red	cord for April					
		•					
	documented the Z-flow was being used on 4/30/12 only, and skin prep to the left heel had been done. A						
		et for May indicated					
		rder, dated 4/30/12, for					
		eels, but there was no					
		on the treatment					
		had been done. The					
		rd indicated an order to					
		ed, dated 5/11/12, and					
		ed starting 5/12/12.					
		3					
	In an interview	with the DoN (Director					
		6/21/ at 3:45 p.m., she					
	indicated Resid	dent #20's pressure					
	ulcer to the left	heel was found on					
	4/30/12 and wa	as being caused by					
		Resident #20's shoe.					
	She indicated						
	documentation	of floating the heels					
	prior to 4/30/12	2 and the					
	documentation	of using the Z-flow or					
	floating the hee	els from 5/1/12 until					
	5/12/12 had not been done.						
		and and an investigation of Decision of					
	3. A closed re	cord review of Resident					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/26/2012	
	PROVIDER OR SUPPLIER		3001 G	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
	indicated the resident was admitted to the facility on 1/28/12.				
	1/28/12, indica left hip incision	ed, "Nursing essment," dated ted Resident #88 had a with 26 staples but no ny area to the left heel.			
	Ulcer Assessmindicated Resider pressure ulcer admission, designed length by 4.5 cdepth was una The treatment assessment was shift, float heel gripper socks we 2/28/12, the we 3.5 cm in width and a stage of treatment was low air loss ma On 3/6/12, the as a 2.5 cm in width a stage E	sis/Arterial/Diabetic lent, dated 2/22/12, dent #88 had a left heel not present on scribed as a 3.5 cm in m in width and the ble to be determined. indicated on the as Skin Prep every s, no shoes, and when out of bed. On bound was described as a by 5.0 cm in length E color black and the Skin Prep, float heels, ttress, and no shoes. wound was described length by 3.5 cm in E.			
	alteration in sk 2/8/12, indicate	ed, Potential for in integrity," dated ed Resident #88 was at nobility and diabetes.			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED	
ANDILAN	or connection	155723	A. BUILDING	00	06/26/2012
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	PROVIDER OR SUPPLIER	2		ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS	EVANS	SVILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
1710		ns included but were	1710		BATE
	not limited to assess skin for				
	changes, turn a	and reposition every 2			
	hours, pressure reducing mattress and heels off bed.				
	The treatment	shoots for Eabruary			
		sheets for February cated Resident #88			
		els floated in bed, no			
		ıled, wear gripper non			
	skid socks. No	documentation of this			
	was noted on t	he treatment sheets.			
	In an interview	with the CRCA			
		dent Care Associate)			
	•	/22/12 at 10:30 a.m.,			
	•	here was not a place			
	on the activities	s of daily living kiosk			
	•	cument heels being			
	floated.				
	3.1-35(g)(2)				
	0.1 00(9)(2)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155723	B. WING		06/26/2012
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF F	PROVIDER OR SUPPLIEF	₹		SALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS	EVANSVILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0309 SS=D	WELL BEING Each resident m must provide the services to attair practicable phys psychosocial we	e/SERVICES FOR HIGHEST  ust receive and the facility e necessary care and n or maintain the highest ical, mental, and ell-being, in accordance with ive assessment and plan of	F0309	F 309	07/26/2012
	Rased on obse	ervation interview and			0772072072
	record review, ensure 1 of 3 pain managem who met the crimanagement. It services to pre (Resident #1)  Findings included 1. The clinical was reviewed a.m. The recording of the control of	ervation, interview, and the facility failed to residents reviewed for the facility failed to residents reviewed for the facility failed to receive the facility of pain received treatment and the vent and treat pain.  The facility failed to resident and treat pain.  The facility failed to receive of pain received treatment and treat pain.  The facility failed to receive of pain received treatment and treat pain.  The facility failed to residents and treat pain.		Res #1 has current pain assessment and interventions place and staff that care for hit have been inserviced on these Completion Date 7-26-12  There were no other residents affected by the alleged deficie practice and through correctiv actions will ensure residents with pain will have timely interventions. Completion Date 7-26-12	m e. s nt e vith
	Accident) (a str hemiparesis.  The most recer Data Set (MDS 06/07/12, indic experienced m impairment, rec	nt quarterly Minimum 3) assessment, dated ated Resident #1 oderate cognitive quired extensive wo for transfers, and		Licensed nurses will be inserviced on pain assessment/management.  Completion Date 7-26-12  DHS/Designee will interview 3 random residents/week includeresident #1 for pain management x1 month and 3 random resident per month thereafter.  Results of audits will be	ing ent

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155723	B. WIN			06/26/2012
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-
					ALAXY DR	
RIVER P	OINTE HEALTH CA	MPUS		EVANS	VILLE, IN 47715	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1	perienced moderate			forwarded to QA committee	for
	pain.				review of compliance and suggestions monthly x6 and	
					quarterly thereafter.	
		rvation of care on			quarterly increasion	
		2 p.m., Hospice Nurse				
		were providing				
		due to leakage to				
		Resident #1 was				
		at time to be grimacing				
	throughout the	procedure and stated,				
	"That is so tend	der!" At that time, the				
	skin surroundin	g the stoma was				
	observed to be	bright red, raised,				
	shiny, and exco	oriated. LPN #1				
	stated, at that t	ime, "It's horrible				
	looking, but it d	id look like				
	hamburgerwh	nen he goes [has a				
	bowel moveme	nt] it just sits on that				
	skin and then it	leaks." LPN #1 was				
	then observed	to apply a new				
	colostomy appl	iance to the excoriated				
	skin surroundin	g the stoma.				
	During an obse	rvation of care on				
	06/20/12 at 10:	20 a.m., Resident #1				
	was transferred	by CRCA (Certified				
	Resident Care	Associate) Preceptor				
	and Hospice N	urse #1 from bed to a				
	high back whee	elchair via a Hoyer lift.				
	In an interview	at that time, Resident				
	#1 complained	of pain in his left arm.				
		as observed, at that				
	time, to not have a sling on his left					
	arm.	· ·				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		A. BUILDING 00			(X3) DATE SURVEY COMPLETED 06/26/2012	
			B. WING STREE	T ADDRESS, CITY, STATE, ZIP COD		72012
	PROVIDER OR SUPPLIE POINTE HEALTH C			GALAXY DR NSVILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	06/21/12 at 11 #1 and CRMA Resident #1 fr shower chair. time, Resident experiencing p Resident #1 w time, to not ha arm.  A plan of care 03/30/12, iden chronic pain w included, but v repositioning, administerpr medications. T included an ac dated, 06/20/1 [medicine] as after care"  A plan of care hospice include to, intervention signs/sympton such as facial [complaint of] promptly, notif and hospice if not alleviated treatment regi	In the plan of care diditional intervention 2, offer pain meds needed before and didted 06/18/12, for ed, but was not limited as "observe for as of pain or discomfort, grimacing, c/o pain,treat per order by MD [medical doctor] pain or discomfort is by current medication				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155723	B. WING		06/26/2012
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE	
RIVER P	OINTE HEALTH C	CAMPUS		GALAXY DR SVILLE, IN 47715	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	``	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
TAG	<b>†</b>	,	TAG	DEFICIENCY)	DATE
		provided by the se on 06/18/12 at 12:10			
	_	ignment Sheet			
	1 '	ident #1 required a			
	splint left arm	-			
		when up			
	The most rece	ent June 2012			
		rder Recap included			
	1	tab 7.5 mg, give 1 tablet			
		ry 4 hours as needed for			
		Lortab 7.5 mg, give two			
		every 4 hours as needed			
		o severe pain.			
		•			
	The June 201	2 Medication			
	Administration	Record indicated no			
	pain medication	on was administered			
	from June 14,	2012 through June 22,			
	2012 at 7:30 a	a.m.			
		v with LPN #1 on			
		50 a.m., she indicated			
	1	appliance had been			
		"for a couple of			
	weeks".				
	The Code alice	e for Dain Assessment			
		s for Pain Assessment			
		nent provided by the			
	HFA (Health Facilities Administrator) on 06/22/12 at 4:00 p.m., indicated,				
		• •			
	"1. cor for those cognitively impairedthe assessor shall observe the resident for pathologic conditions that may cause pain and[facial				
	_	oody movements]5.			

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723			00		LETED 5/2012		
	PROVIDER OR SUPPLIER  OINTE HEALTH CAMPU		B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR  EVANSVILLE, IN 47715					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	IENT OF DEFICIENCIES IST BE PERCEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Educate thecare management intervine importance of notify changes in pain sta	entions and ing staff of						
	3.1-37(a)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155723	B. WIN			06/26/2	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER						
חוייבם ח		MDUS	3001 GALAXY DR EVANSVILLE, IN 47715				
RIVERP	OINTE HEALTH CA	MINIPUS		EVAINS	VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0312 SS=D	RESIDENTS A resident who is of daily living rec to maintain good personal and ora Based on obse record review, the ensure 1 of 3 re ADL's (Activitie the sample of 3 for review of AL	VIDED FOR DEPENDENT  s unable to carry out activities eives the necessary services nutrition, grooming, and all hygiene.  rvation, interview, and the facility failed to esidents reviewed for s of Daily Living), in s who met the criteria DL's received a shower with dental hygiene.	F03	12	F 312  Res #1 has current intervention for personal care involving showers and dental care being delivered per plan of care and staff that care for him have been inserviced.  Completion Date 7-26-12	9	07/26/2012
	was reviewed of a.m. The recordiagnoses includimited to, CVA Accident) (a strinemiparesis.  Resident #1 was 06/19/12 at 9:0 and was observed mouth odor.  In a family inter 8:54 a.m., the strinemiparesis.	ord of Resident #1 on 6/20/12 at 10:44 rd indicated the ided, but were not (Cerebrovascular oke) with left sided as observed on 0 a.m., lying in bed wed to have a foul  rview on 06/19/12 at spouse of Resident #1 as only had a bedbath months" The			Inservice for nursing staff relat to shower preferences/refusal inability to tolerate and dental hygeine.  Completion Date 7-26-12  DHS/Designee will monitor AD bathing reports and audit 3 random dependent residents for oral care 5x/week for 4 weeks, 2x/week for 12 weeks, and weekly thereafter for proper documentation.  Results of monitoring will be forwarded to QA committee monthly x6 months and quarterly thereafter for review and further recommendations.	or DL or ,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155723	B. WING		06/26/2012	
NAME OF F	PROVIDER OR SUPPLIE	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				ALAXY DR		
RIVER P	RIVER POINTE HEALTH CAMPUS		EVANS			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		nad never seen the				
		ral care to Resident #1				
	•	rovided oral care to				
		n the previous day. as observed at that				
		disheveled and to				
	have foul mou					
	i nave ioui ilioui	ui odoi.				
	In an interview	with Hospice Nurse #1				
		10:18 a.m., she				
		nad bathed and				
		ent #1. She further				
		at time that the facility				
		the oral care after he				
	was gotten up					
	l mae gemen ap					
	In an interview	on 6/20/12 at 10:18				
	a.m., with Hos	pice Nurse #1 she				
		nad provided no ADL				
		aily Living) assistance				
	to Resident #1	•				
	In an interview	on 06/20/12 at 10:20				
	a.m., CRCA P	receptor indicated she				
		roviding ADL (Activities				
	of Daily Living)	care to Resident #1.				
	CRCA Precept	tor was observed to not				
	provide dental	care to Resident #1.				
		with the spouse of				
		n 06/20/12 at 10:36				
	· ·	ated Resident #1 had				
		bath that morning.				
		licated Resident #1 had				
	been dressed	while he was in bed by				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE: 06/26/201				
		155723	B. WING			06/26/	2012
NAME OF F	PROVIDER OR SUPPLIER				ALANY DD		
RIVER P	OINTE HEALTH CA	AMPUS			ALAXY DR VILLE, IN 47715		
				1110	VILLE, IIV 7// IU		A15
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	CRCA (Certifie	d Resident Care					
	,	ceptor and no dental					
	care had been	•					
	Resident #1 wa	as observed on					
	06/20/12 at 10:	45 a.m., in the main					
	lobby at a musi						
	uncombed hair	and foul mouth odor.					
	[	W 000A D					
		with CRCA Preceptor					
		10:56 a.m., she					
		[Resident #1] a partial					
	pain inis momi 	ng before breakfast."					
	Δ Rathing Deta	il report, provided by					
		tor #2 on 06/21/12 at					
		icated Resident #1 had					
	· ·	shower or full bath in					
		s. During an interview,					
		OS Coordinator #2					
		are should be included					
	in personal hyg	jiene.					
	In an interview	with CRMA (Certified					
		cation Associate) #1 on					
		29 a.m., she indicated,					
		nis own teeth if we take					
		throom while he is					
	_	neelchair." CRMA #1					
		d the resident received					
	hospice service	es for bedbaths.					
	A plan of some	datad 03/20/12 for					
		dated 03/30/12, for t, "needs assistance or					
		personal hygiene,					
	l is achemaciil	.personai nyglene,		l			I

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	te survey IPLETED 26/2012	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3001 GALAXY DR EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	needed includir	ersonal hygiene as ng oral care,". The eked any specific ated to bathing.					
	Data Set (MDS 06/07/12, indicate experienced management, recomment, recomment, recomment, recomment.)	nt quarterly Minimum ) assessment, dated ated Resident #1 oderate cognitive quired extensive wo staff for bathing and ne.					
	06/13/12, was periodicated Resident Res	dent #1 required stance for hygiene and ould receive a bath on					
	3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(C)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION (X3) D		DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED	
		155723	A. BUII B. WIN			06/26/2012		
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				ALAXY DR			
DIVED D	OINTE HEALTH CA	MBUS			VILLE, IN 47715			
RIVER	OINTE HEALTH CA	MINE US		EVAINS	VILLE, IN 47715			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0314	483.25(c)							
SS=G		/CS TO PREVENT/HEAL						
	PRESSURE SOI							
		mprehensive assessment of						
		cility must ensure that a						
		ers the facility without oes not develop pressure						
	-	individual's clinical condition						
		at they were unavoidable;						
		aving pressure sores						
		ary treatment and services to						
		prevent infection and						
	prevent new sore	es from developing.						
	Based on recor	d review and	F03	14	F 314		07/26/2012	
	interview the fa	acility failed to ensure						
		ted without pressure			Resident #20 was a closed			
		-			record.			
		evelop unstageable			Resident #88 was a closed			
		residents reviewed			record.			
	-	cers in a sample of 4			All regidents have the netention	l to		
	who met the cri	teria for pressure			All residents have the potentia be affected by the alleged	1 10		
	ulcers. Reside	nt # 20's heel wound			deficient practice therefore at r	riek		
	worsened and i	required transfer to the			individuals have been assesse			
		dent #20 and Resident			to ensure prevention interventi			
	#88)				are in place and careplans			
	1100)				updated.			
	Findings includ				Completion Date 7-26-12			
	Findings includ	Ե.						
					Through inservices and chang			
		of Resident #20 was			in documentation procedure v	vill		
	reviewed on 6/2	21/12 at 3:00 p.m. The			ensure that interventions are			
	resident was ac	dmitted to the facility			carried out to prevent ulcers fro	om		
	on 04/17/12. T	he Nursing Admission			developing or worsening			
		form of 04/17/12 did			Completion Date 7-26-12			
		kin condition concern			Systemic change will include			
		esident's left heel.			signing on TAR to reflect heels	3		
	regarding the R	soluento icit neel.			floating.	-		
	<b>A</b> OI :	10:			Completion Date 7-26-12			
	•	ent Circumstance			-			
	investigation, d	ated 04/30/12,			Nursing staff will be inserviced	on		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155723	B. WING	<u></u> _		06/26/2012	
	PROVIDER OR SUPPLIED POINTE HEALTH CA			3001 G/	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN 47715	(X5)	
PREFIX		ICY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	documented a Stage 1 with prinjury. The Pressure/Stasi Ulcer form indipresent on adr 3.0 X 3.0 and the determined was obtained of Prep to the left needed along to provide community when in bed to The left heel with the left heel with the left heel with and a new order specialty dress and as needed A Physician's condicated Residuals and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and on 05/08/12, the left heel cleanser and a three days and on 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and a three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and three days and On 05/08/12, the left heel cleanser and On 05/08/12, the left heel clean	left heel pressure area, possible deep tissue  s/Arterial/Diabetic cated the area was not mission and measured the depth was unable to a A physician's order on 04/30/12 for Skin theel every shift and as with a Z-flow (a device plete pressure relief) float the heels.  as measured again on the measurements e Pressure Ulcer form as 04/30/12.  dated, 05/05/12, the death and an area to the red bed and slough the er for Optifoam (a sing) every three days labeled.  order, dated 05/05/12, dent #20 was to have the eansed with wound apply Optifoam every las needed.  the Pressure Ulcer dicated the heel wound labeled and slough the eansed with wound apply Optifoam every las needed.			new documentation procedure well as repositioning requirements and pressure rel Completion Date 7-26-12  DHS/designee will audit TAR's daily for heel floating documentation. DHS/Designee will conduct da rounds to ensure that pressure reduction interventions are be carried out for a random samp of 3 residents/day x4 weeks, ti 3 residents/week thereafter.  Results of audit as well as fu skin report will be forwarded the QA committee monthly x months and suggestions/recommendatio carried out as deemed necessary by committee.	e as lief.  silly e ing le hen  II to 12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155723	A. BUILDING 00 COMPLETED 06/26/2012				
		155725	B. WIN		PPPPGG GYPY GWARE GYP GODE	00/20/	2012
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
mo	(centimeters) X unstageable.	<u> </u>		1110			DITE
	indicated an or	order, dated 05/08/12, der to revise the to be done every as needed.					
	p.m., indicated dressing was re	dated 5/11/12 at 12:00 the left lower extremity emoved and there was ration with multiple new bunds.					
	time indicated acute change to new order was	dated 5/11/12, with no Resident #20 had an o the left foot and a received to send o the emergency room.					
		r, dated 5/11/12, dent #20 was to be ergency room.					
	(MDS), dated 5 resident as bei developing pre	ta Set Assessment 5/1/12, coded the ng at risk for ssure ulcers but did ressure areas coded at					
	as at risk for sk	skin condition, d, identified the resident kin areas on lower e to disease process					

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPLETED		
		155723	B. WIN			06/26/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
חויירם ה	OINTE LIEALTH OA	AMPLIC			ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup> DEFICIENCY)	
TAG				TAG	BEI ICIENCI)	DATE
	·	y of cellulitis and n. The interventions				
		ere not limited to				
		itus and prevent				
	pressure to are	•				
	piessule to ale	d3.				
	Δ care nlan title	ed potential alteration				
	•	, dated 4/30/12 and				
	reviewed 6/1/12					
		cluding but not limited				
		it left heel, no shoes,				
	wear non skid					
		f pressure relieving				
	devices.	· p· · · · · · · · · · · · · · · · · ·				
	A treatment red	cord for April				
		e Z-flow was being				
		2 only, and skin prep				
	to the left heel	had been done. A				
	treatment shee	t for May indicated				
	there was an o	rder, dated 4/30/12, for				
	Z-flow to the he	eels, but there was no				
	documentation	on the treatment				
	sheet that this	had been done. The				
	treatment recor	d indicated an order to				
	float heels in be	ed, dated 5/11/12, and				
	was documente	ed starting 5/12/12.				
	In an interview	with the DoN (Director				
		6/21/12 at 3:45 p.m.,				
	she indicated F					
		to the left heel was				
	•	12 and was being				
		ssure from Resident				
		ne indicated there was				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 06/26/2012			
		155723	B. WIN			06/26/2012
NAME OF F	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE  ALAXY DR	
RIVER POINTE HEALTH CAMPUS				VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		tion of floating the	+	TAG		DATE
	heels prior to 4	•				
	•	of using the Z-flow or				
		els from 5/1/12 until				
	5/12/12 had no					
	0/12/12 1144 116	a soon done.				
	2. The closed	record of Resident #88				
		on 6/22/12 at 11:19				
	a.m. The reside	ent was admitted to the				
	facility on 1/28	/12. The Nursing				
	Admission Ass	_				
	Collection form	of 1/28/12 did not				
	indicate a skin condition concern					
	regarding the r	esident's left heel.				
	The February 2	2012 treatment sheet				
		ly skin assessments				
	•	d for Resident #88 on				
	· ·	4/12, and 02/21/12.				
		assessments indicated				
	an existing are	a of impairment.				
	A core plan titl	ad notantial for				
	A care plan title	•				
		in integrity, dated				
	· ·	ed Resident #88 was at				
		nobility and diabetes. ons included but were				
	not limited to a					
		and reposition every 2				
	_	e reducing mattress				
	and heels off b	_				
		cu.				
	The Pressure/S	Stasis/Arterial/Diabetic				
		ed 02/22/12, indicated				
	the area was n					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155723	B. WING		06/26/2012	
NAME OF E	PROVIDER OR SUPPLIE		STREET A	ADDRESS, CITY, STATE, ZIP CODE	<b>!</b>	
NAME OF I	NO VIDER OR SOLITEIE	K.		ALAXY DR		
RIVER P	RIVER POINTE HEALTH CAMPUS		EVANS	VILLE, IN 47715		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		measured 3.5 cm X				
		e depth was unable to				
		. The form indicated				
		was Skin Prep every				
		s, no shoes, and				
		when out of bed. The				
		on 2/28/12, the wound				
		olor, staged as "E"				
	, •	neasured 3.5 cm X 5.0				
		atment was Skin Prep,				
	· ·	air loss mattress, and				
		e form indicated on				
		und was unstageable 2.5 cm X 3.5 cm.				
	and measured	2.5 CIII A 5.5 CIII.				
	A doctor's orde	er, dated 2/22/12,				
		dent #88 was to have				
		off heel every shift and				
	· ·	shoes, wear gripper				
		in bed and float heels				
	in bed.	on bed and noat needs				
	in bea.					
	The treatment	sheets for February				
		icated Resident #88				
	was to have he	eels floated in bed, no				
		aled, wear gripper non				
		e February 2012 and				
		eatment sheets lacked				
		ation of heels being				
	1 ,	pes, or gripper nonskid				
	socks.	, G. P. P				
	In an interview	with the CRCA				
	(Certified Resi	dent Care Associate)				
	preceptor on 6	/22/12 at 10:30 a.m.,				

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			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 06/26/2012					
		155723	B. WING			06/26/	2012	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE			
DIVED D	OINTE HEALTH CA	MDHS		3001 GALAXY DR EVANSVILLE, IN 47715				
				l	VILLE, IN 477 15	1	(X5)	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
IAG		nere was not a place		IAG			DATE	
		s of daily living kiosk						
		cument heels being						
	floated.	current neers being						
	noatea.							
	The Pressure F	Prevention Guideline						
		y the HFA (Health						
	•	nistrator) on 6/26/12 at						
		d indicated the facility						
	•	heels off the bed-avoid						
		tectors' and protect						
	· ·	at heels as needed						
	Purpose prov	vide measures that will						
		aintain good skin						
	integrity" on res	sidents with potential						
		npairment or skin						
	integrity.							
	3.1-40(a)(1)							
	3.1-40(a)(2)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155723	B. WING		06/26/2012		
				ADDRESS, CITY, STATE, ZIP CODE	I.		
NAME OF I	PROVIDER OR SUPPLIE	R		SALAXY DR			
RIVER P	OINTE HEALTH C	AMPUS	EVANSVILLE, IN 47715				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0323 SS=D	The facility must environment ren hazards as is por receives adequal assistance device. Based on observed record review, ensure chemical and out of read 3 units observed closet was left unattended with (Transitional Composer of the compos	tervision/Devices tensure that the resident mains as free of accident basible; and each resident ate supervision and ces to prevent accidents. ervation, interview, and the facility failed to cals were kept locked ch of residents for 1 of ed. A housekeeping unlocked, open, and th chemicals inside. care Unit 600)  de:  3:00 p.m., a closet was observed hed wide, and the Transitional Care following items were e closet:  Incentrate disinfectant habel included, but was the following Geep out of reach of inful if swallowed. Atraction Carpet label included, but was label included, but was label included, but was label included, but was	F0323	F 323  There were no residents affect by the alleged deficient practic and through corrective actions ensure hazardous chemicals a locked up.  Completion Date 7-26-12  All departments will be inservion proper care and storage of chemicals.  Completion Date 7-26-12  Housekeeping supervisor/designee will rando audit all closets daily to ensure items are secured.  Results of monitoring will be forwarded to QA committee monthly x6 months and quarterly thereafter.	ce s will are ced		

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	OF CORRECTION  OF CORRECTION  155723	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/26/2012			
	PROVIDER OR SUPPLIER POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR  EVANSVILLE, IN 47715					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION			
	and slight skin irritant. First aide, flush eyes, flush skin, ingestion two large glasses of water. Do NOT induce vomiting. Call physician.						
	The Administrator provided a document entitled "Daily Cleaning Procedures Resident Rooms," on 6/26/12 at 11:55 a.m. Documentation included, but was not limited to, the following: "Pull your stocked cart in front of the room that you are cleaning. Make sure that you do not leave chemicals on the top of the cart and that your cart is locked." In interview at this time, she indicated it was the only documentation she could find of requiring chemicals to be locked up.  3.1-45(a)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155723	B. WIN			06/26/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t .			ALAXY DR		
RIVER P	OINTE HEALTH CA	MPHS			VILLE, IN 47715		
					VIELE, IIV 17710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0328	483.25(k)	ARE FOR SPECIAL NEEDS					
SS=D		ensure that residents					
	•	eatment and care for the					
	following special						
	Injections;						
	Parenteral and e	enteral fluids;					
	Colostomy, urete	erostomy, or ileostomy care;					
	Tracheostomy ca	are;					
	Tracheal suction						
	Respiratory care	;					
	Foot care; and						
	Prostheses.			• 0			0=10<10010
			F03	28	F 328		07/26/2012
	Based on obse	rvation, interview, and			Decident #4 has consuled		
	record review,	the facility failed to			Resident #1 has careplan	m) /	
		esidents reviewed for			updated to reflect current osto care and appliance.	Шу	
		ne sample of 2 who			Completion Date 7-26-12		
	met the criteria	•			Completion Bate 7-20-12		
					There were no other residents		
	_	eived prompt care and			affected and through inservicir	ng	
	_	ment. Resident #1			will ensure residents with	J	
	experienced lea	_			ostomies have proper care and	d	
	colostomy appl	liance being applied on			treatment of it.		
	excoriated skin	that resulted in			Completion Date 7-26-12		
	Resident #1 ex	periencing pain when					
		vas changed and			Licensed nurses will be		
	• •	tion to the skin from			inserviced on ostomy care and	1	
		ostomy appliance.			treatment.  Completion Date 7-26-12		
	une in-intuing coi	ostorily appliance.			Completion Date 1-20-12		
	Eindings indud	lo:			DHS/designee will audit reside	ents	
	Findings includ	E.			with ostomies: careplans,		
		<b></b>			peristoma condition and		
		#2 and LPN #1 were			appliance/tx 3x/week for 2		
	observed on 06	6/18/12 at 2:52 p.m.,			months, weekly for 2 months a	and	
	providing colos	tomy care due to			monthly thereafter.		
	leakage to Res	ident #1. Resident #1					
	_	at that time to be			Results of audits will be		
		ughout the procedure			forwarded to QA committee		
	griniacing tillot	agricut tric procedure			monthly x6 months and		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/26/	ETED
NAME OF I	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	00/20/	2012
RIVER P	OINTE HEALTH CA	AMPUS			ALAXY DR VILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	and stated, "The that time, the second was observed to approtective barriarea before apwafer to the collimited to, CVA	iat is so tender!" At kin surrounding the erved to be bright red, and excoriated.  at that time, LPN #1 dent #1 was receiving al antifungal colostomy excoriation. at that time, "It's y, but it did look like nen he goes [has a ent] it just sits on that the leaks" The Hospice to that time, "we are ut Thursday (6/21/12) new appliance." LPN poserved to cleanse the estoma with moistened ly a new colostomy e excoriated skin toma. LPN #1 was not ply any cream or er to the peri stoma plying the colostomy			quarterly therafter.		

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f ´			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155723	B. WING	G		06/26/	2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS'	VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The most recer	nt quarterly MDS					
	(Minimum Data	Set Assessment),					
	dated 06/07/12	, indicated Resident #1					
	had an ostomy						
		Physician's Order					
	•	d, but was not limited					
	to, the following	•					
		al 2% cream apply to					
	stoma every da	•					
		tomy care every shift					
	03/30/11 Chan	ge ostomy bag and					
		ee days and as					
	needed peri sto	oma area cleanse.					
	_	Progress Note, dated					
		ated, "site at ostomy					
		.substancial [sic]					
		d his ostomyostomy					
	site candidiasis	5"					
	The Niversian at Ni	otoo from 06/07/40 -t					
	_	otes from 06/07/12 at					
	•	gh 06/21/12 at 1:00					
		ewed and lacked any					
		that the attending					
	• •	peen notified the					
	colostomy appl						
	iunctioning due	to the excoriated skin.					
	A plan of some	datad 06/19/12 for					
	•	dated 06/18/12, for					
	•	ed, but was not limited					
	to, intervention						
		s of pain or discomfort,					
	such as facial of						
	[complaint of] p	pain, moaning or					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPL	ETED
		155723	A. BUI B. WIN			06/26/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF P	PROVIDER OR SUPPLIER	8			ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
				<u> </u>	, , , , , , , , , , , , , , , , , , ,		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BLI ICILIACI)		DATE
		nents and treat per					
		, notify MD [medical					
	doctor] and hos	•					
	discomfort is no	ot alleviated by current					
	medication trea	atment regimen"					
	A plan of care	for skin condition,					
	dated 06/11/12	, for "irratiation [sic] at					
	stoma site" witl	h interventions that					
	included, but w	ere not limited to,					
		changes in skin status,					
		t changes in skin					
	• •	protective barrier					
	cream as order						
	l cream as order	eu.					
	A plan of care	for pain, dated					
		-					
		fied a problem of					
		th interventions that					
		vere not limited to,					
		eft arm sling when up,					
	administerprr						
	medications. T	•					
	included an ad	ditional intervention					
	dated, 06/20/12	2, offer pain meds					
	[medicine] as n	needed before and					
	after care"						
	A plan of care	for ostomy, dated					
		ded, but was not					
	· ·	ventions "observe					
	ostomy site dai						
	,	ngnotify physician of					
	any problems	•					
	In an interview	on 6/20/12 at 10:18					

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	OF CORRECTION  OF CORRECTION  155723	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	TE SURVEY MPLETED 26/2012			
	PROVIDER OR SUPPLIER POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR  EVANSVILLE, IN 47715						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	a.m,. with Hospice Nurse #1 she indicated the new colostomy supplies "will be taken care of by the hospice wound care person on 06/21/12."							
	In an interview with LPN #1 on 06/22/12 at 9:50 a.m., she indicated the colostomy appliance had been changed daily "for a couple of weeks" and there had been no change to the type of colostomy appliance used for Resident #1.							
	In an interview with the DoN (Director of Nursing) on 06/22/12 at 10:00 a.m., she indicated the plan of care for the ostomy had not been revised to address the periwound rash, alternate treatment, or the colostomy appliance. The DoN further indicated at that time, the physician had not been notified of the rash around the stoma interfering with the functioning of the colostomy appliance.  3.1-47(a)(3)							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155723	B. WIN	LDING		06/26/	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ALAXY DR		
RIVER P	OINTE HEALTH CA	MPUS		EVANSVILLE, IN 47715			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0332 SS=D	5% OR MORE The facility must	CATION ERROR RATES OF ensure that it is free of rates of five percent or					
		rvation, interview and	F03	32	F 332		07/26/2012
	ensure it was fr rates of five per of 13 residents medication adn errors were ma opportunities for error rate of 6.8 of 4 licensed nu errors.	or error, resulting in an 89 percent. Three (3) urses observed made 1, #8, #179) (RN #1, N #1)			Resident #8 has orders clarified to administer sliding scale as ordered and eliminate the "dorngive more than 8 units with slid scale".  Completion Date 7-26-12  Resident #101 received meds ordered Completion Date 7-26-12  Resident #179 received meds ordered and suffered no ill effection not receiving it with food. Completion Date 7-26-12  RN#1 and RN#2 as well as LF	n't ding as as ects	
	1. On 6/21/12 at 8:14 a.m., RN #1 was observed preparing to administer medications via gastrostomy tube to Resident #101. The RN indicated she had a question about the resident's order. The Medication Administration Record (MAR) was observed to indicate the medication as "Calcium with Vitamin D 600/400 liquid daily per peg tube." The bottle of liquid was observed and indicated a concentration of 1250 milligrams (mg) per 5 milliliters (ml). The label indicated they were to give 6 ml for				#1 and RN#2 as well as LF #1 have completed medication administration course and hav had a med pass observation completed. All other staff that pass meds will be inserviced.  Completion Date 7-26-12  All residents receiving medical have the potential to be affecte by the alleged deficient practic and through inservicing and observations will ensure medications are given as orde Completion Date 7-26-12  DHS/designee will: perform medication pass audit monthly	n e tion ed ee red.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155723	A. BUI. B. WIN			06/26/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ALAXY DR		
DI\/ED D	OINTE HEALTH CA	AMDUS			VILLE, IN 47715		
IXIVLIXI		AWI 03		LVANO	VILLE, IN 477 13		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	600 mg of elen	nental calcium. There			6 months and then quarterly,		
	was no indicati	on of Vitamin D being			review prescribed orders for	_	
	in the liquid. T	he nurse called the			accuracy daily for 2 weeks the one time weekly for one month		
	pharmacy for c	larification. She			then continue with pharmacist		
	l '	harmacist indicated			audits every 60 days.		
		ow the instructions on			, , , , , , , , , , , , , , , , , , , ,		
		um bottle, to give 6 ml			Results of audits will be		
	•	She further indicated the			forwarded to QA committee		
	•				monthly x6 months and then		
		a separate solution			quarterly for review and furth	er	
		to give two drops to			suggestion.		
	<u> </u>	international units					
	ordered.						
	RN #1 was the	n observed to pour an					
	amount of the	calcium liquid into a 30					
	ml measuring of	cup. The cup was					
	1	marked for 2.5 ml, 5					
		ml, 15 ml, 20 ml, 25 ml,					
		e liquid level was					
		tween the 5 ml and 7.5					
		indicated she was					
		s she prepared to move					
		medication, she					
	summoned and	other staff person and					
	asked that pers	son to go get her a 10					
	ml syringe.						
	RN #1 was the	n observed to draw up					
		uid into the syringe.					
		et's see how close I					
	· ·	en indicated the syringe					
		, ,					
		syringe was observed					
	and it held 5.6 ml of the calcium						
		ger was not equal to					
	the 6 ml line.	The nurse was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155723	B. WIN	IG		06/26/2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		neck the amount again.				
	· ·	e added some calcium				
	liquid to equal	the 6 ml.				
		the 2 drops of Vitamin				
		she administered the				
	medications.					
	Danisla 1 #404	a alluiaal na aassi				
		s clinical record was				
		21/12 at 11:57 a.m.				
		s orders included an				
	· ·	25/12, for Calcium with				
		400 liquid daily per peg				
		as no clarification of				
		medication label,				
		at that time, indicated				
	1	to administer 6 ml of				
	the Calcium.					
	0 0 0/04/40	1.44.44				
		at 11:14 a.m., LPN #1				
		to check the blood				
		ent #8. The blood				
		ndicated the resident's				
		as 242. LPN #1				
	· ·	at time, the resident				
		red Humalog 4 units				
		meal. She indicated				
		as to receive 6 units for				
		of 242. She was then				
		aw up 10 units of				
		n and administer it				
		y into Resident #8's				
	abdomen.					
	Resident #8's o	clinical record was				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155723	B. WIN	G		06/26/2012	
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIEN				ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS		EVANS'	VILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		)N
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		22/12 at 11:00 a.m.					
		cated the physician's					
		6/18/12, indicated					
		Units/ML vial inject 4					
	•	h each meal **Do not					
	_	8 units with SS [sliding					
	scale]."						
	Humalog SS:  '	'201-250= 4 units"					
	I DN #1 was int	terviewed, at that time,					
		the had given 10 units;					
	it was a mistak	•					
	i it was a mistak	e.					
	3. On 6/22/12	at 7:47 a.m., RN #2					
	was observed t	·					
		Resident #179. The					
		cluded, but were not					
		ollowing: Aspirin 325					
		) one tablet by mouth					
		um supplement) 20					
		(meq) one tablet by					
	mouth.	(meq) one tablet by					
	No food was gi	ven with the					
		he resident had not					
	had breakfast a						
İ	Resident #179'	s clinical record was					
	reviewed on 6/2	22/12 at 8:23 a.m. The					
	physician's ord	ers, signed 6/19/12,					
	indicated the o						
	medications we						
		25 mg i po (by mouth)					
	,	norning) with breakfast					
	' ' ' ' '	i po bid (twice a day)					
	take with meal						
	Lanc will meal	or oridon					

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Event ID: KFT311

Facility ID: 002280

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155723	B. WIN			06/26/	2012
NAME OF P	ROVIDER OR SUPPLIER				ALANY DD		
RIVER D	OINTE HEALTH CA	AMPHS			ALAXY DR VILLE, IN 47715		
				<u> </u>	VILLE, IN 477 15	1	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	KEGOE/TOKT OK	ESC IDENTIFICATION OR MATTER OF	+	1710	·		DATE
	The resident w	as observed to receive					
		ay on 6/22/12 at 8:30					
	a.m.	ay 011 0/22/12 at 0.30					
	a.iii.						
	4 The Medica	tion Administration					
		ral Guidelines, dated					
		11, was provided by the					
		se on 6/18/12 at 12:10					
		y and procedure					
	•	as not limited to, the					
		dications that have					
	_	at specific time shall be					
	administered a	t the time designated					
	by the attendin	g physician."					
	"Medications th	nat are to be received					
	prior to, with or	after meals shall be					
	administered a	t these times yet in					
	accordance wit	h the resident's					
	self-determined	d schedule"					
	3.1-25(b)(9)						
	3.1-48(c)(1)						

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Event ID: KFT311

Facility ID: 002280

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	DDIC	00	COMPL	ETED
		155723	A. BUII B. WIN			06/26/	/2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ALAXY DR		
DIVED D	OINTE HEALTH CA	MDUS			SVILLE, IN 47715		
RIVER	OINTE HEALTH CA	AMPUS		EVAINS	5VILLE, IN 477 15		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371	483.35(i)	_					
SS=F	FOOD PROCUR	•					
		RE/SERVE - SANITARY					
	The facility must	from sources approved or					
		factory by Federal, State or					
	local authorities;						
		e, distribute and serve food					
	under sanitary co						
		rvation and interview,	F03	71	F 371		07/26/2012
	the facility failed	d to ensure frozen			The freezer is in ourrent working	20	
	foods were stor	red in the freezer			The freezer is in current working order and with working	ig	
	below zero deg	rees and bins			thermometer. All freezers and		
	containing dry f	foods were not			fridges have a temperature log	j in	
	_ ,	ential contamination in			place. All opened containers a	-	
	•	potentially affecting 39			dated and dry bulk storage lids	5	
		ate at the facility.			are in place.		
	residents who t	ate at the facility.			Completion Date 7-26-12		
	Findings includ	e:			There were no residents affect	ted	
					by the alleged deficient practic		
	#1. During the i	initial kitchen tour on			and through corrective actions		
		0 a.m., an observation			ensure storage of frozen foods		
		n exterior freezer			and dry food storage contained	rs	
		egistering 20 degrees			have lids secured.  Completion Date 7-26-12		
					Completion Date 1-20-12		
		by the entrance door of			Dietary employees have been		
		ne interior thermometer			inserviced on food storage,		
	_	a temperature due to			sanitation, food handling and s	safe	
	•	e indicator line being			temperature food code		
	broken and loo	se in the thermometer.			regulations.		
					Completion Date 7-26-12		
	In an interview	during the initial tour,			Director of food continued decimal	100	
		ces Assistant indicated			Director of food service/design will monitor and/or verify freezo		
	the exterior the	rmometer was broken			temps at or below 0 degrees	Ci	
		interior thermometer.			daily and conduct sanitation/fo	od	
		here was not a log of			storage audits daily.		
		res for this freezer.			]		
	uany temperatu	1163 101 11113 1166261.			Results of audits will be		

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Event ID: KFT311

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		ONSTRUCTION 00	(X3) DATE S COMPLI		
		155723	A. BUI B. WIN	LDING IG		06/26/	2012
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
RIVER P	OINTE HEALTH CA	AMPUS			ALAXY DR VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	On 6/18/12 at a observation was interior freezer entrance door or registering 25 c. On 6/18/12 at a observation was freezer thermost the entrance do registering 10 c. Record Review a.m., of the refit temperature log no record of passervation was freezer by the electron of 6/19/12 at 8 observation was freezer thermost the entrance to 0 degrees. The registered 10 d. In an interview on 6/19/12 at 8 the problem was temperature problem.	11:43 a.m., an as made of the new thermometer by the of the kitchen degrees.  3:28 p.m., an as made of the interior meter of the freezer by for of the kitchen degrees.  4 on 6/18/12 at 10:30 rigerator/freezer g indicated there was ast temperatures for the entrance to the kitchen.  3:30 a.m., an as made of the interior meter in the freezer by the kitchen registering exterior thermometer egrees.  with the Administrator as not a freezer oblem. The exterior as broken and the meter temperature was degrees because the rees had been opening		TAG	forwarded to QA committee monthly for 6 months and quarterly thereafter for review and further recommendations		DATE
	it to retrieve for	od.					

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Event ID: KFT311

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If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	CIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MU		MULTIPLE CONSTRUCTION X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	١G	00	COMPL	ETED	
		155723	B. WING			06/26/	2012	
NAME OF I	PROVIDER OR SUPPLIE	D	S	TREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	ROVIDER OR SUFFEIL	K	3	001 G/	ALAXY DR			
RIVER P	OINTE HEALTH C	AMPUS	E	'VANS	VILLE, IN 47715			
(X4) ID		STATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE	
	0 0/00/40 /	0.00						
	On 6/20/12 at							
		as made of the exterior						
		ometer on the freezer by						
		trance registering 38						
	-	interior thermometer						
		degrees. There was no						
		ezer at this time. The						
		Assistant indicated the						
		eated up overnight and						
	was not workii	ng at that time.						
	#2 An observ	vation during the initial						
		2 10:35 a.m., was made						
		cottage cheese						
	•	full with no date to						
		ay the cottage cheese						
		In an interview at this						
		Food Services Assistant						
		someone had forgotten						
	to date the cot	tage cheese.						
	#3 During ini	tial kitchen tour on						
		37 a.m., a bin of flour						
		to be open with the lid						
		ss the bin, but not						
	1	·						
	_	in of flour. A box with a						
	Day of bulk Su	gar was open to air.						
	An observation	n was made on 6/21/12						
		of a box with a bag of						
		t. The bag was wide						
	open to air.							
	'							
	A document p	rovided by the						

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Event ID: KFT311

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/26/2012
	POINTE HEALTH C		STREET 2 3001 G	ADDRESS, CITY, STATE, ZIP CODE ALAXY DR SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and titled Store 2009, indicate be stored in ple tight covers or sanitized. The open package stored in close frozen storage zero degrees. Thermometers every freezer	6/26/12 at 9:45 a.m., age Procedures, dated d dry bulk food was to astic containers with bins which are easily document indicated s would be dated and ed containers and temperatures would be Fahrenheit or below. S would be placed in and temperatures would in the freezer log at ay.			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155723	B. WIN	G		06/26/	2012
	ROVIDER OR SUPPLIER			3001 G	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN 47715		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
F0411 SS=D	483.55(a) ROUTINE/EMER SERVICES IN S The facility must routine and 24-h  A facility must proutside resource §483.75(h) of this emergency dentates of each resident; resident an addited emergency dentates appointments; and transportation to and promptly refudamaged dentures are sident with partial dentures residents review who met the cric (Resident #15)  Findings included Record review p.m., indicated care plan for defeigler. The coresident had a interventions in concerns were the resident or	RGENCY DENTAL NFS assist residents in obtaining our emergency dental care.  ovide or obtain from an in accordance with spart, routine and all services to meet the needs may charge a Medicare itonal amount for routine and all services; must if the resident in making and by arranging for and from the dentist's office; er residents with lost or es to a dentist.  rvation, interview, and the facility failed to referral to a dentist for loose and ill- fitting in a sample of 3 iteria for dental care.	F04		F 411  Resident #15 suffered no ill effects from the alleged deficient practice and doesn't wish to have dental consult completed Completion Date 7-26-12  There were no other residents affected by the alleged deficier practice and through use of dental questionnaire will ensur there is follow up of consults. Completion Date 7-26-12  Systemic change is the addition of dental questionnaire completor all new admissions by Soci Service Director for follow up. Completion Date 7-26-12  Social Service Director/designwill update the dental log as	nt re on eted al	07/26/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DD1G	00	COMPLE	ETED
		155723	A. BUILI			06/26/2	2012
			B. WING	_	ADDRESS STATE OF CODE		
NAME OF F	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP CODE		
DIVED D		AMPLIO			ALAXY DR		
RIVERP	OINTE HEALTH C	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	plan, dated 6/	12/12, indicated the			referenced in F272 POC daily	to	
	resident would be assisted with				ensure that medical record		
	oral/denture ca	are.			contains sufficient information		
	Gran acritar o care.				and description of follow up		
	Interview with	Resident #15 on			required.		
	6/19/12 at 11:34 a.m., indicated				Log Results of Social Service	_	
		-			monitoring that includes	·	
		had missing teeth and			residents with dental issues		
		related to his loose			will be forwarded to QA		
		artial and his lower			committee monthly for review	w	
	dentures. The	e resident indicated his			and further suggestions x 6		
	top partial is u	nable to be anchored to			months and quarterly		
	his permanent	teeth and when he			thereafter.		
	wore the uppe	er partial the wires would					
	hurt his mouth	•					
	Hart His Hisati	•					
	Observation o	n 6/21/12 at 8:30 a.m.,					
		•					
		staff offered to brush					
		s teeth. The resident					
		e his upper partial plate					
		placed in his mouth.					
	The resident in	ndicated the wires that					
	anchored the	partial plate to his					
	permanent tee	eth hurt his teeth					
	whenever the	wires touched them					
		ot been wearing it. The					
		ed his bottom denture					
		but had difficulty					
		ttom denture into his					
	,	(Unit Manager) #1 had					
	l '	also put the resident's					
teeth into his mouth but was unable to							
	do so. Resident #15 indicated the						
	bottom dentur	e was too big to go into					
	his mouth.						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155723	B. WING		06/26/2012		
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE			
				ALAXY DR			
RIVER P	OINTE HEALTH C	AMPUS	EVANS	SVILLE, IN 47715			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
		vith LPN #1 on 6/21/12					
	· ·	he indicated she did					
		esident's teeth were					
		o one had reported it to					
	her.						
		:11 000 (0 : :					
		rith SSD (Social					
		gnee) #1 on 6/22/12 at					
	· ·	indicated she was					
		esident had any dental					
		dicated she was					
		esident had a care plan					
		regarding his loose					
	· •	indicated no one had					
	reported to her	•					
	residents dent	ures or partial plate.					
	The policy for a	oral care guidelines,					
		the ED (Executive					
		22/12 at 4:00 p.m. and					
	•	licated in providing					
	· ·	es, any changes noted					
		ere to be reported to the					
	nurse.	ire to be reported to the					
	3.1-24(a)(3)						
	2 <b>2</b> .(a)(b)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155723	B. WING		06/26/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				
DIV (ED. D.		MPLIO		ALAXY DR	
RIVER P	OINTE HEALTH CA	AMPUS	EVANS	VILLE, IN 47715	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0425 SS=D	483.60(a),(b) PHARMACEUTI PROCEDURES,	CAL SVC - ACCURATE RPH			
	The facility must emergency drugs residents, or obta agreement descripart. The facility personnel to adn permits, but only supervision of a last A facility must preservices (includir the accurate acquand administerin biologicals) to me resident.  The facility must services of a lice	provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed ninister drugs if State law under the general			
	provision of phar	macy services in the facility.	F0425	F 425	07/26/2012
	record review, to provide routine to 1 of 13 reside the medication order for Calcius not clarified, was liquid solutions, admittedly were Vitamin D. (Resident of the control of the contr	e not always giving the sident #101)		Resident #101 had order clarif Completion Date 7-26-12  RN#1 has completed medicatinal administration course and has had a med pass observation completed. All other staff that pass meds will be inserviced. Completion Date 7-26-12  There were no other residents with this order but through corrective action will ensure the the order is clearly labeled and separate by pharmacy if the 2 meds are not in 1 solution.	on
	On 6/21/12 at 8	3:14 a.m., RN #1 was		Completion Date 7-26-12	

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLI	
		155723	B. WING			06/26/2	2012
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ALAXY DR		
RIVERP	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		*		IAG	DEFICIENCT)		DATE
TAG	observed prepared medications via Resident #101. she had a quest resident's order Administration observed to incomplete as "Calcium with liquid daily performed fliquid was obtained as "Calcium with liquid daily performed fliquid was obtained as "Calcium with liquid daily performed fliquid was obtained they was no indicated they was no indicated in the liquid. They harmacy for condicated the plant she should follow the liquid calcium of the liquid calcium of the liquid. So with a liquid calcium of the liquid calcium of the liquid. So with a liquid calcium of the liquid. So with liquid calcium of the liquid calcium of the liquid calcium of the liquid. So with liquid calcium of the liquid calcium of the liquid calcium of the liquid. So with liquid calcium of the liquid calcium of the liquid calcium of the liquid. So with liquid calcium of the liquid calcium of the liquid calcium of the liquid. So with liquid calcium of the liquid calcium of the liquid calcium of the liquid calcium of the liquid calcium of the liquid. So with liquid calcium of the liquid calcium of the liquid calcium of the liquid. The liquid calcium of the liquid calcium of the liquid calcium of the liquid. So with liquid calcium of the liquid calci	r. The Medication Record [MAR] was dicate the medication th Vitamin D 600/400 peg tube." The bottle beserved and indicated of 1250 milligrams diters [ml]. The label were to give 6 ml for mental calcium. There con of Vitamin D being the nurse called the larification. She tharmacist indicated by the instructions on the further indicated the the separate solution to give two drops to meternational units  amin D solution, was observed. It full. It was filled on Medication		TAG	DHS/designee will: perform medication pass audit monthly 6 months and then quarterly, review prescribed orders for accuracy daily for 2 weeks the one time weekly for one month then continue with pharmacist audits every 60 days.  Results of audits will be forwarded to QA committee monthly x6 months and then quarterly for review and furth suggestion.	r for en	DATE
	Calcium with V been given dail RN #1 indicated	Record indicated the itamin D 600/400 had by 6/1 through 6/20/12. d, at that time, she had am previously in June.					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155723	B. WIN	IG		06/26/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
D., (ED. D		ANADULO			ALAXY DR		
RIVERP	OINTE HEALTH CA	AMPUS		EVANS	VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		the initials on previous					
	1	s, but she had not					
		tamin D at that time;					
		own it was a separate					
	solution.						
	DN #4 #						
	RN #1 was then observed to pour an amount of the calcium liquid into a 30						
	1	cup. The cup was					
		e marked for 2.5 ml, 5					
		ml, 15 ml, 20 ml, 25 ml,					
		e liquid level was tween the 5 ml and 7.5					
		indicated she was					
		s she prepared to move					
		medication, she					
		other staff person and					
	ml syringe.	son to go get her a 10					
	i ilii syinige.						
	DN #1 was the	n observed to draw up					
		uid into the syringe.					
	· ·	et's see how close I					
	· ·	en indicated the syringe					
		syringe was observed					
		ml of the calcium					
	the 6 ml line.	ger was not equal to					
		heck the amount again.					
		ne added some calcium					
	liquid to equal						
	inquiu to equal	uio o iiii.					
	She did include	e the 2 drops of Vitamin					
		she administered the					
	medications.	ano administrato tha					
	medicalions.						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155723	LDING	00	COMPL 06/26/	ETED
	PROVIDER OR SUPPLIER		3001 G/	DDRESS, CITY, STATE, ZIP CODE ALAXY DR VILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	reviewed on 6/2 The physician's order, dated 5/2 vitamin D 600/4 tube. There was the order. The reviewed again	s clinical record was 21/12 at 11:57 a.m. s orders included an 25/12, for Calcium with 400 liquid daily per peg as no clarification of medication label, at that time, indicated to administer 6 ml of				

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Facility ID: 002280

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155723	(X2) MULTIPLE C  A. BUILDING	ONSTRUCTION  00	(X3) DATE COMPI <b>06/26</b>	ETED
	PROVIDER OR SUPPLIER		3001 (	ADDRESS, CITY, STATE, ZIP CODE GALAXY DR SVILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION COI SPREAD, LINEN The facility must Infection Control provide a safe, s environment and development and and infection.  (a) Infection Con The facility must	NTROL, PREVENT US establish and maintain an Program designed to anitary and comfortable to help prevent the d transmission of disease  trol Program establish an Infection				
	infections in the (2) Decides what isolation, should resident; and (3) Maintains a recorrective action	controls, and prevents facility; t procedures, such as be applied to an individual ecord of incidents and s related to infections.				
	(1) When the Info determines that a prevent the spre- must isolate the (2) The facility m communicable d lesions from direct their food, if direct disease. (3) The facility m hands after each	ust prohibit employees with a isease or infected skin ct contact with residents or ct contact will transmit the ust require staff to wash their direct resident contact for ning is indicated by accepted				
	transport linens of infection.  Based on obse	handle, store, process and so as to prevent the spread rvation, interview, and the facility failed to	F0441	F 441		07/26/2012

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLI	ETED
		155723	B. WIN			06/26/2	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ALAXY DR		
RIVER P	OINTE HEALTH CA	AMPUS			VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		<u> </u>		IAU	Res #15 suffered no ill effects		DATE
		n control procedures			from the findings on the 2567L		
		for 3 of 7 residents			and staff have been inserviced		
	· ·	ersonal care, in that			glove usage/changing and		
	_	and glove use were not			handwashing.		
	performed as required. (Resident				Completion Date 7-26-12		
	#15, Resident	#87, Resident #78)			Dec #07 and #70 auffared re-		
					Res #87 and #78 suffered no in effects and through corrective		
	Findings includ	le:			actions will ensure that glove		
					usage/changing and		
	1. During an o	bservation on 6/21/12			handwashing occur per policy	to	
	at 8:30 a.m., L	.PN #1 and Unit			prevent spread of infection		
		#1 assisted Resident			Completion Date 7-26-12		
	#15 to the bathroom. LPN #1 and						
		their gloves without			All residents have the potential be affected by the alleged	ιι το	
		nands before placing			deficient practice and through		
	_	the commode. UM #1			alterations in processes and		
		esident's brief and			inservicing will ensure correcti	ve	
					actions to prevent spread of		
		clothing to the resident			infection are followed.		
	_	ng her gloves or			Completion Date 7-26-12		
	washing her ha	ands.			Nursing staff will be inserviced	lon	
					proper handwashing and glov		
	2. CRMA (Cert				usage procedures to prevent		
		sociate) #1 was		spreading of infection.			
		sist Resident #87 to			Completion Date 7-26-12		
		ısing a Sara lift (a					
	mechanical de	vice with a sling used			DHS/Designee will monitor		
	for position cha	anges) on 06/21/12 at			resident care that includes handwashing/glove usage after	<u>,                                    </u>	
	11:00 a.m. In	an interview on			care and techniques of all care		
	06/21/12 at 11:	:05 a.m., CRMA #1			provided daily x5days, 3xweel		
	indicated Resid	dent #87 had urinated.			2 weeks, then weekly.	-	
		RMA #1 was observed					
	· ·	care to Resident #87.			Results of audits will be		
	CRMA #1 was observed, at that time,				forwarded to QA committee		
		the soiled gloves			monthly x6 months and		
		g the resident's			quarterly thereafter for review	w	
	I perore applying	y ine residents	1		and further		

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  I OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION  00	i í	ATE SURVEY MPLETED
	155723	A. BUILDING B. WING		<b>—</b> 06/	26/2012
	PROVIDER OR SUPPLIER POINTE HEALTH CAMPUS	STREET . 3001 G	ADDRESS, CITY, STATE, ZIP C BALAXY DR BVILLE, IN 47715	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	incontinence brief and clothing.		suggestions/commen	ts.	
	The guidelines for handwashing, provided by the HFA (Health Facilities Administrator) 6/22/12 at 4:00 p.m. and dated 10/04, indicated all health care workers should wash their hands frequently and appropriately. Health care workers are to wash their hands after removing gloves, after having direct contact with residents, having direct contact with excretions, and having direct contact with resident equipment. The guidelines lacked any information regarding changing gloves between clean and dirty procedures.				
	3. An observation was made on 6/21/12 at 09:30 a.m., of CRCA (Certified Resident Care Associate) #3, CRMA (Certified Care Medication Associate) #1, and UM (unit manager) #1 giving incontinence care to Resident #78. CRCA #3, CRMA #1, and UM #1 entered the room and applied gloves without washing hands. They then assisted the resident into bed with a mechanical lift. CRCA #3, CRMA #1, and UM #1 rolled Resident #78 to the left and CRMA #1 wiped Resident #78 with incontinent wipes and removed the dirty brief. CRMA #1 changed gloves				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/20/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE COMPL		
ANDILAN	or conduction	155723		LDING		06/26/	
		100720	B. WIN		Paragram and the grant control	00/20/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  ALAXY DR		
RIVER POINTE HEALTH CAMPUS					VILLE, IN 47715		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
		g hands put a new					
		nt #78 and put rolled					
		trash bag. CRMA #1					
		s and carried bag to Ilway touching the					
		CRCA #3 put Resident					
		able in place then					
		s and continued out					
		side of CRCA #3.					
	_	the dirty bag into the					
		nt to the nurses'					
		n washed hands.					
		n mached hande.					
	3.1-18(I)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155723		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED				
<u></u>		155723	B. WING		06/26/2012			
NAME OF PROVIDER OR SUPPLIER  RIVER POINTE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR  EVANSVILLE, IN 47715					
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION			
R0244	(1) scheduled ad Based on obsethe facility failed medications we multiple resider identification duadministration dassisted living described by the facility of the cup. Upon out four separate of the cup. Upon out four separate medication cup medicated the medicated the medicated separate out four separate out four separate out four separate out on Unit 200. The cup out four separate out on Unit 200. The cup out four separate out of the cup out of the cup out four separate out of the cup out	- Noncompliance of doses for more than one Iministration is not permitted. rvation and interview, d to ensure ere not set up for ints without proper uring medication observed on 1 of 2 units. (Unit 200) es: 3:30 p.m., a medication wed unlocked and side a resident room the drawer was easily the was in sight of the et top drawer, there souffle type the with assorted tets and capsules. the resident room and	R0244	R 244  LPN #2 was terminated from employment.  All residents have the potent be affected by the alleged deficient practice and through medication inservicing will ethat meds are not set up for than 1 scheduled administration and without identifying mark Completion Date 7-26-12  Licensed personnel will be inserviced on medication administration and complete test for understanding.  Completion Date 7-26-12  AL manager/designee will perform medication administration observation a 3x/week for 1 month and the 3x/month randomly on all sh with all AL nurses.  Results of audits will be forwarded to QA for review monthly x 12 months.	tial to gh nsure more ation ings.  e post  audits en hifts			

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NAME OF PROVIDER OR SUPPLIER RIVER POINTE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately informed of the observation. She	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  RIVER POINTE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately	l 155723			A. BUILDING B. WING		
RIVER POINTE HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG PROVIDERS PLAN OF CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIEN	NAME OF P	ROVIDER OR SUPPLIE	<u> </u>	STREET		
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  OCMPLETION TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  TAG  THE Administrator was immediately						
PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately  PREFIX PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  COMPLETION DATE  COMPLETION TAG  TAG  PREFIX TAG  TAG  PREFIX TAG  TAG  PREFIX TAG  COMPLETION DATE					5 VILLE, IIN 477 15	(V5)
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  anywhere on the cups. She stated, "I just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately					(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
just know who gets what." At that time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		
time, she began picking up all the cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately		•	•			
cups with medications in them and indicated she would throw them away and start over.  The Administrator was immediately		•	•			
indicated she would throw them away and start over.  The Administrator was immediately		_	- ·			
The Administrator was immediately		=				
		and start over.				
		The Administra	ator was immediately			
,			•			
indicated, at that time, the nurse						
should not be setting up multiple			•			
resident medications in advance of the medication pass without						
identification of each resident's			· ·			
medications.		medications.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155723		A. BUII B. WIN			06/26/	2012	
			B. WIN		DDDECC CITY CTATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
	OINTE LIEALTIL OA	MPLIC			ALAXY DR		
RIVER POINTE HEALTH CAMPUS				EVANS	VILLE, IN 47715		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	A10 IAC 16.2-5-6 Pharmaceutical S (e) Medicine or tr shall be appropri except when auth present. All Sche by the facility sha containers under substantially con mobile drug stora Based on obse record review, the ensure medicate when out of vie for 1 of 2 assist 200).  Finding include  On 6/21/12 at 3 cart was observe the 200 unit. The derivation was slight was in sight of the drawer was observed and the sight of the drawer souffle com medication table drawers contain packaged medications.	Scenario de Services - Deficiency reatment cabinets or rooms ately locked at all times horized personnel are edule II drugs administered all be kept in individual redouble lock and stored in a structed box, cabinet, or age unit.  Tryation, interview and the facility failed to the facility failed to the facility failed to the facility failed to the facility failed to the facility gunits (Unit seed living units (Unit seed living units (Unit seed outside a room on the medication cart the drawers easily oor to the resident thy opened. No one the cart. The top served to contain 15 tups with assorted ets in them. The other need bubble pack type to cations belonging to	R03	TAG	R 304  All residents have the potential be affected by the deficient practice and through corrective measures and in-servicing stative will ensure that med carts a locked when out of view.  Completion Date 7-26-2012  Licensed nursing personnel will be in-serviced on the proper material security procedures.  Completion Date 7-26-2012  AL manager/designee will aud med carts for proper security/storage randomly on a shifts 3x/week for 2months and then 3x/monthly.  Results of the audits will be forwarded to the QA committed monthly for 6 months and quarterly thereafter.	I to e ff are iil ned	
	She indicated s	the resident room. The had left the cart indicated the pills in					

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	of Correction identification number: 155723	A. BUILDING	00	COMPI 06/26	LETED	
	PROVIDER OR SUPPLIER	B. WING O6/26/2012  STREET ADDRESS, CITY, STATE, ZIP CODE  3001 GALAXY DR				
	OINTE HEALTH CAMPUS	EVANS	VILLE, IN 47715			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	the souffle cups were for her medication pass.					
	The Administrator provided the policy and procedure for medication storage in the facility, dated 2/1/10, on 6/26/12 at 11:55 a.m. The policy included, but was not limited to, the following:  "Medications and biologicals are stored safely, securely, and properly The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications."  "Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access."					

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